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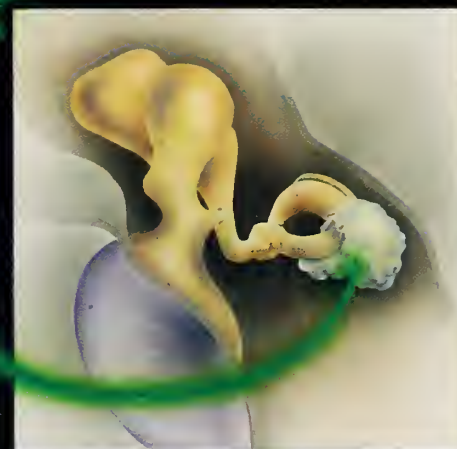
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**SURGICAL APPLICATIONS OF THE LASER
IN THE EAR AND BRAINSTEM**

JANUARY 1997
VOLUME 95, NUMBER 1



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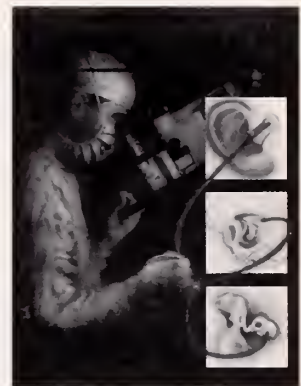


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COVER STORY	Surgical Applications of the Laser in the Ear and Brainstem (Grand Rounds) <i>Alan J. Nissen, MD</i>	13
SCIENTIFIC	Rheumatoid Arthritis and the Pulmonary Nodule <i>Robert W. Byrd, MD; Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD</i>	19
SPECIAL ARTICLE	The Kentucky Medical Curriculum A Response to the Call for Educational Reform: A GPEP Report Card <i>Robert F. Rubeck, PhD; H. David Wilson, MD; Emery A. Wilson, MD; Roy K. Jarecky, EdD</i>	25
EDITORIALS	<i>Criticism and Medicine</i> <i>Stephen Z. Smith, MD</i>	35
ASSOCIATION	<i>Monitoring Medicine</i> William T. Applegate Named KMA Executive Vice President Patrick T. Padgett and Brett A. Leichhardt Join KMA Staff News	7 39 40 41
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Classifieds Information for Authors	5 46 37 45 18



COVER: The adaptation of laser technology has resulted in improved techniques in treating a variety of otologic and neurologic diseases. Artwork by Lee Wade of Eminence, Kentucky. (With permission to reprint from Dr Nissen.)

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William H. Mitchell, MD

If I Heard Him Right, Here's What He Said:

Fortunately, only a very few of us are afflicted with the obsessive condition that follows political campaigns closely. Since I am a person suffering from such an affliction, I have followed President Clinton's campaign closely. His successful campaign for re-election was completed, and on November 5, 1996, President Clinton was re-elected for a second 4-year term in office.

Compiling and reviewing my notes on the Presidential campaign, there are several areas of interest to physicians that we will track in the coming months. Some of these areas are Medicare/Medicaid, Abortion, Tort Reform, Health Reform, and Taxation.

With regard to Medicare/Medicaid there is a stated intention to preserve the healthcare benefits for 38 million elderly and disabled Medicare recipients without imposing new increases on the premiums for these services. The rationale for this, as

stated during the campaign, is that the Democratic balanced budget proposal will maintain fiscal integrity for the Medicare Trust Fund for the next 10 years. At the same time it will lead to a \$125 billion savings for over 7 years.

"Compiling and reviewing my notes on the Presidential campaign, there are several areas of interest to physicians that we will track in the coming months."

This balanced budget proposal also includes preservation and enhancement of long-term care and preventive services by Medicare; for example, colorectal screening, diabetic management, respite care, and mammography.

The budget plan is also intended to protect funding for medical education and teaching and research institutions.

With regard to Medicaid, their proposal is one of broad based and flexible privatization to be implemented by individual states. The intention is to maintain the federal guarantee of Medicaid. As such, the intention seems to be to retain the financial commitment to the states with regard to Medicaid while costs are controlled by the states by imposing a per capita limit on expenditures for services.

With regard to Tort Reform, the Product Liability Reform Bill which

included limits on medical malpractice awards was vetoed by President Clinton after it cleared Congress. The rationale for the veto was a concern that consumers would be denied legal recourse. It seems likely that President Clinton will follow a similar course with regard to tort reform measures in the future.

With regard to Abortion, President Clinton has stated that he believes that the decision regarding abortion should be between a woman and her doctor. As such, he supports the right of women to make their own decisions regarding reproductive choices. His actions during the first term had been consistent with this position in that he abolished the gag rule with regard to federally funded clinics' ability to provide information regarding reproductive choices.

Early in 1996, he vetoed legislation banning late term abortions. The rationale was that the bill failed to protect women from serious threats to their health. At the same time, he has a stated opposition to the use of the procedure on an elective basis. He has stated that it should be available when there are serious and adverse health consequences for the mother and

used only in a small number of cases where, in the physician's judgment, abortion is necessary to save the life of the mother.

With regard to Taxation, only modest tax relief is proposed for the second term. An example is ostensibly aimed at encouraging businesses to hire long-term welfare recipients. This measure would allow employers to claim a \$5,000 tax credit for each person they employ that has been on welfare for more than 18 months. There are other tax incentives to encourage businesses to invest in distressed inner-city neighborhoods. He has also proposed a tax break of up to \$500,000 for home owners in capital gains relief when their homes are sold.

His contention is that if Congress adopts his balanced budget plan then he will not ask for a tax increase for the next 4 years.

With regard to Health Reform, the beginning of his first administration was marked by an unsuccessful attempt to establish sweeping reform in our national healthcare system. In moving to a more centrist position, he has accepted the idea of an incremental approach.

He recently signed new legislation that offers employees greater health insurance protection by making insurance coverage portable and limiting exclusions based on pre-existing medical conditions. The emphasis seems to be on making it easier for small businesses to buy and maintain affordable health insurance for workers. This can be accomplished through voluntary purchasing cooperatives. In addition to this, increasing the tax deduction for health care premiums for the self employed and making it possible for states to provide home and community based services without federal waivers.

As such, his positions during the 1996 campaign show an extension but moderation in a consistent manner with his position on these issues from the beginning of his first term in office.

Since each one of these areas will have an effect on our patients, we are obliged to follow and make continuous assessments of how the next years progress.

William H. Mitchell, MD
KMA President

MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

The KMA Board of Trustees met on December 18-19. Numerous reports were presented, three of which relate to legislative and political activities. The 105th Session of Congress will convene on January 7, 1997. The Kentucky General Assembly will meet for 10 days beginning January 7, 1997, to elect leadership and appoint committees. KEMPAC has just completed an outstanding year and plans are being made for 1997. The following reports are timely and important as we begin another year.

KEMPAC Report **William B. Monnig, MD, Chair**

We had a very successful Primary and General Election campaign both on the state and federal levels. Our successes are best highlighted in two races — one on the federal level and one on the state level. Former State Representative Anne Northup (R) unseated Congressman Mike Ward (D) in the third (3rd) Congressional District. While KEMPAC/AMPAC contributed the maximum allowable \$10,000, AMPAC infused an additional \$80,000 into Northup's campaign via the "independent expenditure" provision permitted by the federal election law. Senator Joe Meyer (D) of Covington, went down to defeat losing to newcomer Jack Westwood (R). According to the *Courier-Journal*: "Meyer raised much more money than Westwood, but Northern Kentucky physicians targeted Meyer because of his support for health care reform measures and a tax on health care providers that was repealed this year."

On the Kentucky House of Representatives side, the Democrats enlarged their majority by one seat (64-36). However, many observers believe the Democrat majority, especially those Democrats elected in the past two election cycles are far more conservative than their predecessors. On the Senate side, the Republicans continued pecking away at the Democrats by picking up an additional seat.

The Democrats' hold on the Senate has become more and more precarious (20-18).

If you're keeping score, KEMPAC participated in six federal races and we were 100% successful. KEMPAC was involved in 50 of 100 State House races. We won 24 and lost 11 in the contested races. We also supported 15 other House members who were uncontested in the General but had difficult Primaries and needed the extra support. On the Senate side, we participated in 14 of 18 contested races. Our record was 10 wins and four losses. Don't let the percentages concern you. We "took some shots" at some of our severest critics, but we knew going in that our chances were slim. Unfortunately, in several of those races where medicine's chief critics were running, local physicians failed to mount strong campaigns in support of KEMPAC's efforts.

KEMPAC has made an extensive effort to urge physicians and their spouses to seek elective offices. We also made a commitment to help finance them if they chose to run. We were involved in five races of this nature in the General election, four physicians and one physician's spouse. Ernie Fletcher, MD, lost in the 6th Congressional District; Marshall Prunty, MD, was defeated in the 15th state House District; Phil Hulsman, MD, was upended in the 32nd state House race; and Peggy Henderson (spouse) was defeated in the 7th House District. Former KMA President and KMA Board Member, State Representative Bob M. DeWeese, MD, was reelected in the 48th District in a landslide victory.

The logo for the Kentucky Medical Association (KMA) is displayed in a stylized, bold, outlined font.

CAPSULE

KEMPAC/AMPAC supported 74 candidates/54 were victorious (73%)
KEMPAC/AMPAC members (1995-96) = 1,088
Total Dues Collected 1995-96 = \$108,800

EXPENDITURES

KEMPAC/AMPAC \$103,250
Independent Expenditures 80,000

TOTAL \$183,250

As you can see, Kentucky physician/spouse members received quite a return on their investment.

Despite our relatively small population of physicians, Kentucky ranks 14th in numbers of KEMPAC/AMPAC members. We finished 3rd in terms of meeting our goals — following only New York and North Carolina.

State Legislative Report Wally O. Montgomery, MD, Chair

The 1996 Special Session on Workers' Compensation has adjourned. The Governor, along with General Assembly leadership and members, aggressively attacked the major ills of a bankrupt system. The House overwhelmingly (80-17) passed their version and the Senate adopted the bill 32 to 5. The effort was purely nonpartisan and the Governor is to be congratulated for the political risk he has taken. The reform barely touched on the medical community with several exceptions:

- Workers will not be sent to five or six sets of doctors to justify their condition. Unless disputed by the employer, the treating physician's opinion of partial impairment will serve as the basis for

determination of benefits. If this opinion is disputed, independent medical evaluations will be performed by panels established by either the University of Kentucky or the University of Louisville, whose opinion will determine the award.

- The definition of injury will be amended to return the workers' compensation program to what it was intended to be — to pay medical bills and compensate workers for injuries which result from their work — not for injuries resulting from the natural aging process or other factors. Objective medical evidence must be provided to substantiate a claim.
- Determination of disability due to workplace injuries will become more objective, consistent and predictable. This results in reductions of time and money spent on settling disputes.

The KMA Legislative Quick Action Committee endorsed the legislation and applauded the action of the Administration in a letter to Governor Patton and Lt Governor Henry from President Mitchell and Board Chair Harry Carlross.

Most of the action in the regulatory arena has involved workers' compensation fee schedules, provider service networks, Medicaid fee schedules, repayment of the \$52 million settlement, and proposed regulations relating to school health physicals.

The State Legislative Committee is gearing up for the 1988 Session of the Kentucky General Assembly which is not as far away as some of us would like. We expect to be proactive in 1998 by pursuing KMA's Patient Protection Act — which we introduced in 1996 — and other areas related to managed care. In addition, we have about ten referrals from the 1996 House of Delegates, along with our ongoing agenda, which we pursue with great

diligence.

While we will play the "activist" role, several concerns should be noted:

First, a growing number of national and state newspapers have taken editorial positions praising the Massachusetts legislation that opened physician data bank information to public scrutiny. The momentum to list physician data and liability awards continues to grow at the state level. Massachusetts became the first state to release information about malpractice payouts, disciplinary actions against doctors, and physicians' criminal records.

The *Courier-Journal*, in an op-ed piece noted: "Americans have access to more background information about our cars, food, and mattresses than about our doctors. . . . In a competitive, market-driven system . . . there's no justification for shielding information about physicians."

The *Lexington Herald-Leader* editorialized: "If you're in the market for a new car or a coffee maker, you can readily assemble rafts of information about the performance and repair records of different brands and models. But if you are looking for a doctor to care for your child or remove your appendix, you're pretty much on your own."

House Health and Welfare Chair Tom Burch has already indicated an interest in similar legislation. Therefore, it is important that we begin addressing this issue NOW with our legislators.

Finally, nonphysician practitioners will continue efforts to expand their practices with guaranteed reimbursement. Once again, it is incumbent upon each of us to work with our individual legislators to provide them important information relating to nonphysician practitioners and their role in the system.

There is some sentiment in Frankfort to call a special session on "health care reform" in Kentucky. The need still exists to address the problem of individual insurance for non-group folks. Sentiment is rising to get rid of the remainder of HB 250 which ended up in the 1996 Session as SB 343.

National Legislative Report Donald C. Barton, MD, Chair

We were very pleased with the outcome of the 1996 Kentucky Senate and Congressional races. Of course, Anne Northup's victory was the icing on the cake.

House GOP leaders have drafted a very light schedule for the first two months of the 105th Congress. This sharply contrasts with the opening of the 104th Congress when members worked 80-hour weeks to fulfill the "Contract with America." As it now stands, during January and February, the House will be in session a total of only 15 days. And, if this trend continues, this Congress will have the markings of one that will be very "district friendly."

Another possible advantage of this schedule is the likelihood that the appropriations process will proceed in a timely manner. Of course, it's too early to tell if the 105th Congress will display the kind of partisanship that plagued the last Congress (ie, shutting down the government, temporary spending

measures), but it's a safe bet that this Congress will be less partisan than its predecessor.

Even though several House races remain undecided or in dispute, the Democratic and Republican Congressional caucuses have been busy firming up their leadership ranks. In general, there are very few changes, with most of the top spots staying as they were in the 104th Congress. Embattled House Speaker Newt Gingrich, in particular, retained his position.

In his acceptance speech, Gingrich touched upon what he hopes to accomplish in this session, including a balanced budget agreement, better health care and improved education. Despite the recent clamoring from both sides of the aisle for campaign finance "reform," Gingrich made no reference to the subject in his speech. Insiders suggest that there be some common ground between Congressional Republicans and the President in the tax arena, but that common ground may not include substantial tax cuts. Republicans are also expected to again enact a rule first introduced in the 104th Congress which requires the House to pass any proposed federal income tax rate increase by a three-fifths majority.

Gingrich noted in his acceptance that he will stress cooperation with the White House as a major theme of the 105th Congress, noting that Republicans have an "absolute moral obligation" to work with President Clinton. For his part, Clinton has also made some post-election "bipartisan"

gestures concerning the need for cooperation in coming to an agreement on balancing the budget.

Like the Republicans, House Democrats have retained their leaders for two more years. Back in charge will be Minority Leader Dick Gephardt, Minority Whip David Bonior, and Democratic Caucus Chairman Vic Fazio.

As you are aware, the major targets for reductions to achieve a balanced budget will come from the Medicaid and Medicare budgets. Traditionally, both Congress and Administration rely more and more upon reducing physician and hospital reimbursements to achieve their cost cutting goals. We need to be prepared to lobby our Congressional and Senate representatives in this area. Representatives Rogers, Northup, and Bunning are all in key positions and will play a major role in designing the final budget that passes. Wendell Ford retained his leadership position in the Democrat caucus and Mitch McConnell continues to move up in seniority and power.

All too often, we think the public understands our jargon and can fully converse with us on the ills of our health system. A survey of 1,081 people by Louis Harris found that 55% had never heard the term "managed care" or did not have an understanding of what it meant. Thirty-one percent had never heard the term HMO or didn't know what an HMO was. 25% of individuals who participated in an HMO or PPO did not know that their choice of physicians was limited.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.
- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.
- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.
- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.
- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.


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Surgical Applications of the Laser in the Ear and Brainstem

Alan J. Nissen, MD

The adaptation of laser technology to surgery has resulted in improved techniques in treating a variety of otologic and neurotologic conditions. The purpose of this article is to summarize and discuss the advantages of using lasers in treating pathologic entities of the ear, as well as tumors commonly found in the posterior fossa, and to present three case histories that illustrate practical applications of the laser.

Systems that are currently available are *invisible* wavelength lasers, which are beyond the scope of this article, and *visible* wavelength lasers, including the argon and the potassium titanyl phosphate (KTP-532) laser (Laserscope Surgical Systems, San Jose, CA). In recent years, I have used the KTP-532 laser exclusively, and my co-workers and I have been reporting our experience* and results with its use since 1989.^{1,3}

Advantages of Visible Wavelength Lasers

Visible wavelength lasers, especially the KTP-532, have significant advantages over invisible wavelength lasers. Visible wavelength lasers transmit energy through fiberoptic cables, facilitating access to the intricate chambers of the middle ear, where the beam may then be directed accurately. Visible wavelength lasers do not require any type of carrier beam to be seen by the naked eye. On the other hand, invisible wavelength lasers require a carrier beam to be seen, which can be a potentially serious problem in confining ear spaces. If the carrier beam and the active laser beam are not exactly coaxial, the laser beam may be directed to an unexpected or unwanted anatomic site. Therefore, true visualization of the beam is mandatory for the precise placement of the laser in otologic surgery.

The visible wavelength beam is absorbed by

hemoglobin and not by clear fluid, which is a distinct advantage for coagulation and hemostasis. The hemoglobin absorption capability of the visible wavelength laser minimizes bleeding and helps keep the operative field dry and allows for safer, more efficient surgery.

When the KTP-532 laser is used neurotologically, the beam is focused at the tumor site and passes through the clear spinal fluid. This results in beam activity that may be accurately aimed at the tumor site and not on the surface of the cerebrospinal fluid.

The fiberoptic capability of the visible wavelength laser has enhanced the development of a number of different handpieces that are readily adaptable to the surgeon's preference in selecting access to the surgical site. In recent years, we have been able to get increasingly smaller fibers to deliver the beam with correspondingly smaller handpieces and, again, minimize possible compromise in very tight surgical sites in the middle ear and the posterior fossa. Smaller handpieces also have enhanced the tactile approach for all surgeons, in contrast to the micromanipulator, which in the past has been used exclusively to direct laser beam activity to the surgical site.

Understanding the Laser's Functions

Any discussion of the surgical application of the laser requires an understanding of four terms: *power*, *spot size*, *pulse duration*, and *power density*.¹ The **power** of the beam is its energy output measured in watts. **Spot size** refers to the diameter of the surgical beam that can vary in width from a few microns to millimeters. **Pulse duration** is the amount of time in which the beam actively performs its surgical function, measured in milliseconds. It can be manipulated from a pulsed beam lasting a few milliseconds to a continuous active surgical beam. **Power density** is defined as power per unit volume. The power of

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*I have used lasers in my practice for the past 13 years at the University of Louisville and elsewhere.

Surgical Applications of the Laser in the Ear and Brainstem

the laser beam is constant and, by varying the spot size of the beam at the focal point (ie, the surgical site), the power density of the beam can be significantly altered. It is critical from the surgical standpoint to understand this concept and how it affects outcome.² Power density can be controlled by moving the handpiece that carries the laser beam closer to or farther from the surgical site, thus altering the beam's surgical effects. In other words, when the spot size is made very small or is tightly focused, the power density increases; conversely, by widening the spot size or defocusing the beam, the power density decreases. All of these functions can be varied at any time by the surgeon and tailored to suit the demands of the procedure.

The laser beam's primary surgical effects on tissue are cutting, coagulation, and vaporization, all of which can be manipulated easily and quickly by varying the spot size of the beam and varying the amount of power density delivered to the surgical site¹ (Fig 1).

Tissue cutting (ie, actual tissue removal) requires the highest power density, with a very highly focused spot size. Tissue vaporization also requires maximum power and a very large spot size to allow for better control of the depth of vaporization as the beam proceeds through the tissue. Coagulation, on the other hand, requires

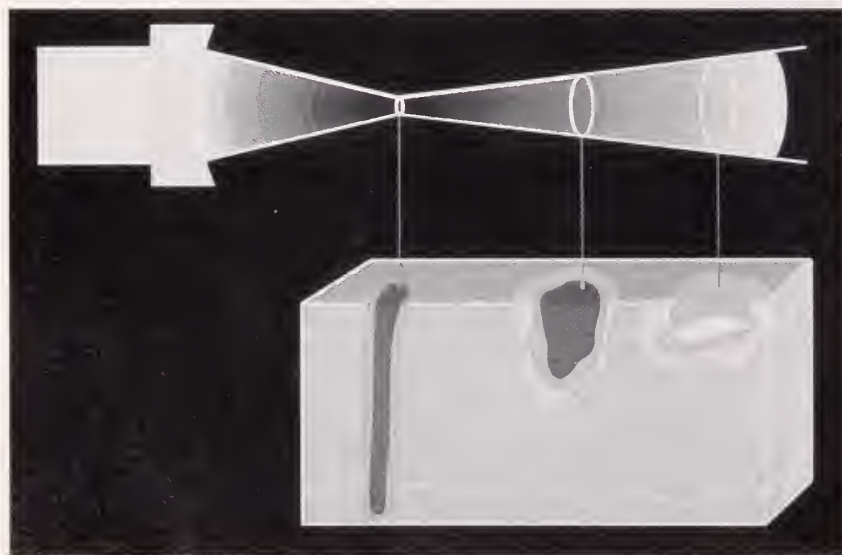


Fig 1 — Very tight focusing of the beam allows for tissue cutting and deeper tissue penetration. The more the beam is defocused, the less tissue depth penetration and the better the coagulation. (Modified with permission from Nissen AJ. *Laser Applications in Otologic Surgery*. *Ear Nose Throat J*. 1995;74:477-482.)



Fig 2 — Examples of handpieces for use with laser fiberoptic cables. The fiber goes through the handpiece and extends from the metal end for its surgical use. (Reproduced with permission from Nissen AJ. *Laser applications in otologic surgery*. *Ear Nose Throat J*. 1995;74:477-482.)

a very large and defocused spot size and a high power setting. Again, because the visible wavelength laser beams are absorbed by hemoglobin, this defocused beam is very useful in coagulating surface vessels.

The laser beam is delivered to the surgical site by a micromanipulator fixed to the microscope, or by a handheld delivery system available in different designs.⁵ Presently, handheld instruments are being used almost exclusively. They are disposable and inexpensive, in sizes and shapes that can be modified (Fig 2). The laser system is activated when the beam passes through fiberoptic cables to a handpiece held by the surgeon. This active beam has minimal divergence as it leaves the fiberoptic cable. Its power density is controlled by focusing and/or defocusing the beam at the surgical site, which is easily accomplished by moving the handpiece either toward the surgical site or away from it, at the focal point. Activated by a foot pedal controlled by the surgeon, the duration of the beam can be delivered by a pulse mode of typically between 0.1 second and a continuous beam, depending on the site of the surgery and preference of the individual surgeon.

Surgical Applications

Middle Ear

Perkins⁶ first described using the visible wavelength laser in treating otosclerosis in 1980. Since

then, the visible wavelength laser has become very useful in ossicular reconstruction, in cholesteatoma removal and in fixed malleus syndrome, as well as in the removal of small vascular lesions in the middle ear, especially adhesions and granulation tissue often associated with chronic ear disease. Specific advantages of using the laser in the middle ear are: (1) The beam can be delivered atraumatically, thereby significantly reducing vibratory injury to the ossicles and, hence, to the inner ear fluids.^{1,7} (2) Excellent hemostasis can be obtained because of the pigment absorption capacity of the visible wavelength laser. (3) The laser can be focused to less than 200 μm , allowing access to very tight spaces in the middle ear with more ease than with standard otologic instruments. The atraumatic use of the laser has allowed us to do many procedures faster, more efficiently, and has increased our ability to treat patients in the hospital as outpatients. The vast majority of all otologic surgery is now done on an outpatient basis, and we think the laser has contributed significantly to obtaining these results.¹

Laser Stapedotomy

The laser has made the laser stapedotomy, in our opinion, the standard surgical treatment for otosclerosis. The technique requires that after the patient's eardrum has been elevated and the middle ear space entered surgically, the laser beam is brought into the operating field with the handpiece. The initial parameters for the laser beam are 2 W of power and a pulse duration of 1/10 of a second. The spot size should be between 100 and 150 μm . One or two "hits," or pulses, of the laser beam focused on the incudostapedial joint prevents mucosal oozing and bleeding. The beam is delivered by the handpiece held in the surgeon's dominant hand, with the smoke evacuator held in the surgeon's other hand. The anterior and posterior crura of the stapes are lasered away with the pulse beam (Fig 3).

Removing the suprastructure of the stapes with the laser has the distinct advantages of reducing cochlear trauma, significantly reducing oozing or bleeding prior to the opening of the footplate, and reducing the chance of a "floating" footplate, where the stapedial footplate floats in the inner fluids rather than being lasered away.

After the crura have been removed, attention is turned to the footplate. At that point, a 0.6 to 0.8 mm opening is made in the footplate using a rosette pattern of overlapping laser pulses, prop-

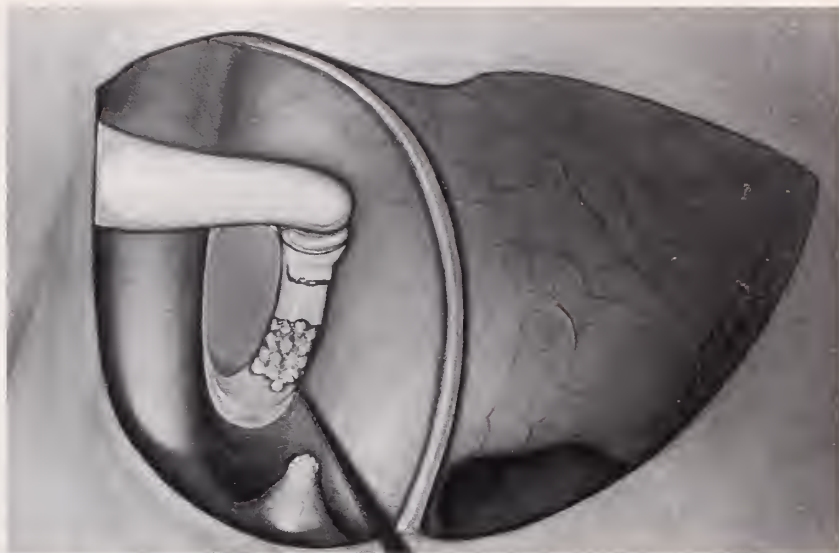


Fig 3 — Laser vaporization of the posterior crus. Small laser "hits" or pulses are visualized on the posterior crus. (Modified with permission from Nissen AJ. *Laser applications in otologic surgery.* Ear Nose Throat J. 1995;74:477-482.)

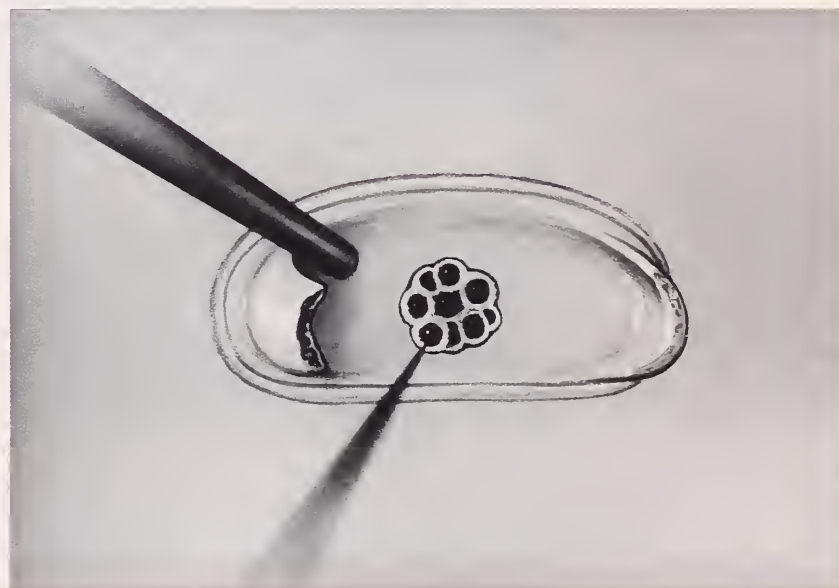


Fig 4 — The "rosette pattern" on the footplate of the stapes made by the laser beam. (Modified with permission from Nissen AJ. *Ear Nose Throat J.* 1995;74:477-482.)

erly positioned directly over the incus (Fig 4). After the rosette pattern is made, the prosthesis is positioned over the incus, and the piston is gently placed in the opening of the footplate (Fig 5).

Surgical Applications of the Laser in the Ear and Brainstem



Fig 5 — Stapes prosthesis positioned in the oval window and crimped on the incus.

In revision stapes surgery, I believe it is absolutely critical to use the laser, which makes it possible to dissect through adhesions and scar tissue around the oval window relatively atraumatically and move through the tissue almost layer by layer, without traumatically manipulating the prosthesis and transmitting vibratory trauma to the inner ear.

Case 1: A 30-year-old woman had progressive bilateral hearing loss of about 3 years' duration that was more pronounced on the left side. She commented that she first experienced hearing loss after the birth of her first child, 10 years earlier. When her second baby was born 8 years later, she reported further hearing loss, causing her significant difficulties in social and professional situations. She denied having dizziness, ringing in the ears, or fluctuation in her hearing levels. She commented that her mother had a hearing loss in her early 30s, and that she wore hearing aids. The results of the patient's head and neck examination were normal, with normal

tympanic membranes and normal middle ear spaces. An audiogram showed bilateral conductive hearing loss, the left ear being worse than the right, at approximately 40 dB. After the patient's condition was diagnosed as bilateral otosclerosis, she consented to undergo laser stapedotomy.

With the patient under local anesthesia, the tympanic membranes were elevated and the ossicles were manipulated through the ear canal. The stapes was frozen into position. The laser was brought into the operating field, and on 2 W of power, one laser hit was made at the incudo-stapedial joint for hemostasis. This joint was then separated with a joint knife and the stapedial tendon was laserd away with 3 W of power on a continuous beam. The laser was then used on the same power settings to remove the posterior crus and the anterior crus of the superstructure. Using the laser on an interrupted beam of 2.5 W of power, a rosette pattern was made in the footplate. The stapes prosthesis was then placed over the incus into the opening of the footplate and crimped into position. The eardrum was replaced, and subjectively, the patient declared a marked improvement in hearing spoken words. She was discharged that day. Her follow-up audiogram at 1 month showed complete closure of the airborne gap and her hearing had returned to the normal range.

Chronic Otitis Media

The laser can be used to treat all types of chronic ear disease. For example, in an ear filled with adhesions and polypoid material, the laser, with a very defocused beam, will allow for surface coagulation to minimize oozing and bleeding while removing diseased tissue, thus reducing the risk of injury and saving time.

The laser is also being used for reconstructive sculpturing of the ossicles. With a tightly focused beam, we have been able to make notches and cuts, or actually shorten the ossicles to fit appropriately. This process is much quicker than drilling when used on ossicles in any reconstructive effort. Vascular middle ear lesions, especially glomus tympanicum, can also be removed with the laser. With a very defocused, low power density beam, surface coagulation of these vessels occurs, which toughens the edges of the vascular lesions and helps us manipulate them until we can reach their stalk and remove them.

Case 2: A 46-year-old man presented with a left-side hearing loss of 6 or 7 years' duration. He

reported having had numerous ear infections as a child, as well as perforation of the tympanic membrane that had drained three or four times a year within the last 25 years. He denied having had dizziness, fluctuation of hearing levels, ringing in the ears or facial nerve weakness. His general medical history was negative. Results of a head and neck examination were normal, except for the left ear, which had a perforation of the tympanic membrane on the posterior half of the drum, with pearly white squamous debris extruding from the eardrum that originated in the middle ear space. An audiogram also revealed a 35 dB conductive hearing loss in the left ear.

The patient's condition was diagnosed as left cholesteatoma with significant conductive loss and probable erosion of one of the ossicles. He underwent surgical exploration of the left middle ear by a post-auricular approach. A large cholesteatoma, originating in the middle ear and extending into the mastoid, was found. An attempt was made to dissect and remove the cholesteatoma by standard techniques. Due to very adherent and deeply seated cholesteatoma around the superstructure of the stapes, the cholesteatoma could not be removed by conventional means without significant trauma to the mobile stapes superstructure. The laser was brought into the operating field with a 400 μ m beam on 5 W of power. Under high-power magnification, the laser was successfully and atraumatically used on a continuous mode beam to remove the cholesteatoma in the tight areas between the stapes superstructure and the facial nerve. We also completely removed cholesteatoma between the arches of the superstructure, which would have been impossible without the laser. The patient had an uneventful recovery and was discharged home later that afternoon.

Posterior Cranial Fossa

We have used the KTP-532 visible wavelength laser extensively to treat acoustic neuromas, meningiomas, and other more uncommon lesions in the posterior fossa.¹ We believe that the KTP-532 laser is distinctly superior to other means of tumor removal because it obtains hemostasis by reducing the amount of bleeding and vaporizes the tumor, which is especially important in the interior of the tumor. Perhaps even more importantly, there is less tugging and pulling on tumor contents, which reduces the amount of tugging on surrounding brainstem structures. This extrapolates to less traumatic pressure on important sur-

rounding posterior fossa structures. Finally, the KTP-532 can be used to cut or remove large tumors.

When posterior fossa tumors are removed, the laser is brought into the field after the tumor has been exposed. Initially, at about 3 W of power, the surface of the tumor is "painted" with the laser beam to accomplish surface coagulation. This cuts down the amount of bleeding once we surgically enter the tumor for removal, and strengthens or toughens the tumor capsule, which aids the surgeon in manipulating it and freeing it from cerebellum and the surrounding brainstem.

Tumor removal and vaporization are accomplished with 12 or 15 W of power on a continuous mode beam. The beam vaporizes the tumor rapidly and allows the surgeon to visualize the depth of the tumor removal as the interior of the tumor is penetrated.

Case 3: A 55-year-old woman had a 5-year history of progressive hearing loss in her right ear. She admitted to having experienced mild "unsteadiness" and ringing in the ear, but denied fluctuation of hearing levels, drainage from the ears, or other otologic problems. An audiogram showed that the patient had primarily high frequency sensorineural hearing loss of about 40 dB, with discrimination scores of 50%. Her auditory brainstem response showed signs of retrocochlear activity in the right ear, and she was referred for magnetic resonance imaging (MRI). The MRI revealed an acoustic neuroma measuring 2.5 cm, which rose from the internal auditory canal and extended into the posterior fossa.

The patient was taken to the operating room where a translabyrinth approach to the acoustic neuroma was undertaken. The tumor was exposed at the internal auditory canal. The facial-nerve monitor was used over the surface of the tumor. To obtain surface coagulation of the duravessels, the laser was passed over the surface of the tumor at 2 W of power on a very defocused beam. The dura was then opened without bleeding. During dissection, the facial nerve was protected, and the tumor was removed. The laser was brought into the field at 10 W of power on a continuous beam, and the interior of the tumor was vaporized. A very high-powered, sharply focused beam then was used to remove the tumor's bulk. After the tumor was completely removed, the patient awakened with normal facial nerve function.

Surgical Applications of the Laser in the Ear and Brainstem

Conclusion

Based on our experience, we believe that visible wavelength lasers, specifically the KTP-532, have significantly reduced the amount of vibratory trauma in treating diseases of the middle ear and the brainstem. The pigment-absorbing properties of the visible wavelength laser has enhanced coagulation capabilities in both the middle ear and posterior fossa. A tightly focused laser beam allows access to very small spaces in the middle ear that were previously very difficult to enter surgically.

The laser has proven to be precise, safe, and efficient, and offers an advantage in treating otologic and neurotologic disease. It has become a standard tool in our treatment armamentarium.

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Rheumatoid Arthritis and the Pulmonary Nodule

Robert W. Byrd, MD; Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD

The potential difficulties offered by the presence of a solitary pulmonary nodule in a patient with rheumatoid arthritis are illustrated by a male non-smoker with clinical, serologic and radiographic rheumatoid arthritis, active and fibrosing alveolitis and a new lung nodule. This nodule proved to be squamous cell carcinoma without the typical risk factors. The finding of a solitary pulmonary density or nodule in a patient with rheumatoid arthritis provides no assurance that the lesion is benign. Both necrobiotic nodules and lung cancer may present as solitary pulmonary nodules in patients with this autoimmune disease.

The intrapulmonary necrobiotic nodule is a well recognized expression of rheumatoid lung disease. These nodules may be multiple or solitary and occur most frequently, but not exclusively, in males with rheumatoid arthritis. Interestingly, they also occur more commonly in patients who smoke cigarettes.¹ The radiographic characteristics of the pulmonary necrobiotic nodule are nonspecific and nondiagnostic.² The clinician who cares for a patient with rheumatoid arthritis and a pulmonary nodule faces an interesting problem.

The well-informed physician may be reassured that the coexistence of bronchogenic carcinoma and rheumatoid lung disease has been reported infrequently. On the other hand, the fibrosing alveolitis of rheumatoid arthritis may lead to usual interstitial pneumonitis (UIP), a condition associated with an increased risk of lung cancer.³ Cigarette smoking, a well documented source of carcinogens, may act synergistically with this autoimmune process to promote lung damage and possibly carcinoma.⁴ Finally, an increase in the frequency of some cancers that are monitored by immunosurveillance has recently been reported in patients with rheumatoid arthritis.⁵

Case Report

A 60-year-old white male with seropositive rheumatoid arthritis and radiographic pulmonary fibrosis was referred for evaluation of a new right sided lung nodule. His only respiratory complaint was mild dyspnea on exertion over the last 6 years. He had been diagnosed with rheumatoid arthritis 15 years earlier. Fibrosing alveolitis was diagnosed by transbronchial biopsies 4 years ago. The pulmonary fibrosis was attributed to his collagen vascular disease. He was treated with prednisone for a 4-month interval at the time the fibrosing alveolitis was diagnosed. He then discontinued corticosteroids due to weight gain and refused any other immunosuppressive therapy for his condition. Aspirin (162 mg) was the patient's only medication. The patient had never smoked tobacco and lacked any significant occupational exposures to lung toxins.

The patient was thin and in no acute distress. Vital signs were unremarkable except for a respiratory rate of 24 breaths per minute. Cardiovascular examination suggested mild cardiomegaly with the PMI displaced laterally. Subcutaneous nodules were present on the extensor surfaces of each arm. Crackles were heard at end-inspiration in both bases. The metacarpal area and MIP joints were swollen and erythematous. There was ulnar deviation bilaterally. Digital clubbing was apparent.

The patient's hemogram was normal. Biochemical profile that included renal and liver function was normal. ESR was 35 mm (normal 0-33 mm). Rheumatoid factor was positive with a titer of 1:640. A moderate restrictive defect was documented on pulmonary function testing and the diffusion capacity for carbon monoxide was significantly decreased (35% predicted). Radiographs of the patient's hands were interpreted as showing changes consistent with rheumatoid arthritis. The standard chest roentgenogram dis-

Rheumatoid Arthritis and the Pulmonary Nodule



Fig 1 — PA chest radiograph documenting bilateral basilar infiltrates and a right lower lobe nodule.

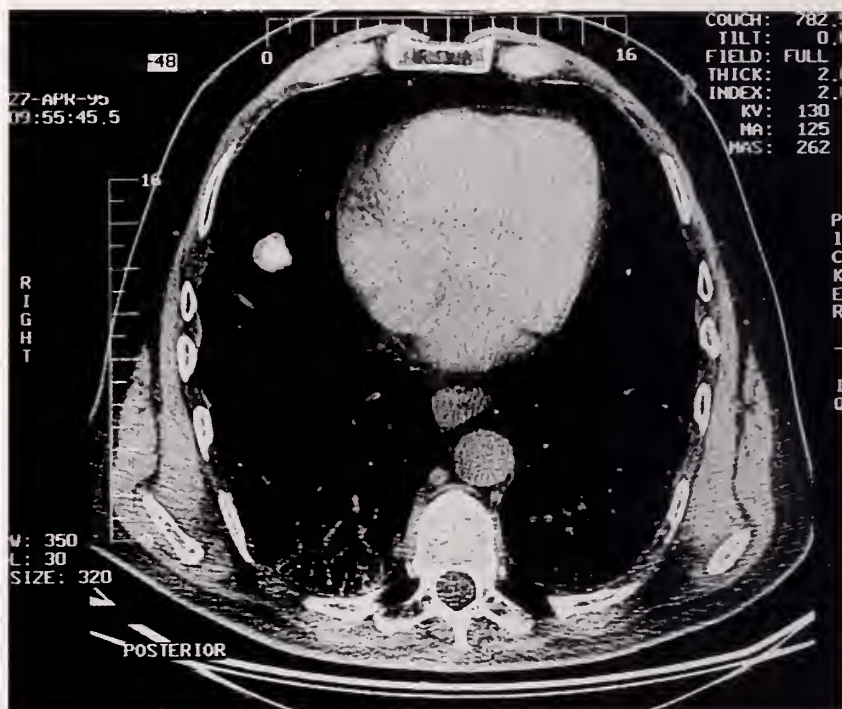


Fig 2 — CT scan of the chest confirming the presence of a right lower lobe nodule.

played bilateral basilar infiltrates. A 1.5×2 cm nodule in the right lower lobe was noted by chest radiograph and CT scan (Figs 1 and 2). Subsequent gallium scanning showed increased activity in both bases consistent with active alveolitis. A fine needle aspiration of the nodule was performed with CT guidance. The specimen contained poorly differentiated squamous cell carcinoma.

Discussion

Necrobiotic rheumatoid lung nodules, as well as other expressions of rheumatoid lung, occur more commonly in males. The nodules are typically multiple and often pleural based. Most frequently, the upper and middle lung zones are involved. It is common for these lesions to occur in association with other manifestations of rheumatoid lung such as fibrosing alveolitis.

Unfortunately, the necrobiotic rheumatoid nodule can have atypical radiographic features that confound the diagnosis. The lesions may occur without any apparent relationship to the course of the patient's systemic complaints, may cavitate, may occur as solitary pulmonary lesions,

and may resolve spontaneously. As mentioned earlier, the occurrence of necrobiotic nodules in the patient with rheumatoid arthritis increases if the patient is a cigarette smoker.¹

Each of the 17 patients reported in the worldwide medical literature with lung cancer associated with rheumatoid arthritis had solitary pulmonary nodules.⁶⁻¹² The demographics are displayed in Table 1. Each of the histologic subtypes of bronchogenic carcinoma that have been found are in Table 2. In addition to the presence of a solitary lung density, nine of the patients also had concurrent radiographic evidence of fibrosing alveolitis. The presence of pulmonary fibrosis may raise the index of suspicion that a solitary co-existing nodule may be neoplastic rather than benign in rheumatoid patients of either gender.

The association between the fibrosis of rheumatoid lung and the development of lung cancer is not entirely understood. It has been observed that the presence of interstitial pneumonitis is associated with lung cancer more frequently than expected by chance alone.³ The bronchoalveolar type of adenocarcinoma would be expected to occur most frequently if this was the only relevant factor, but it has been reported only once with

the interstitial lung fibrosis due to rheumatoid arthritis. Tumorigenesis associated with rheumatoid arthritis is increased in the absence of treatment. However, these tumors are typically lymphomas or myelomas.¹⁴ The explanation for the histologic variance of bronchogenic carcinomas may be due to the small number of reported patients or an anticipated synergy between cigarette smoking and altered immunity that has yet to be defined.⁴ Nevertheless, the risk of malignancy tends to be somewhat increased in the patient who has smoked tobacco and in the patient with concurrent pulmonary changes of fibrosing alveolitis.

Clinical and serologic features of rheumatoid arthritis lack definite association with the occurrence of lung cancer. Bronchogenic neoplasms have occurred independent of tobacco use, independent of treatment with immunosuppressives, irrespective of the level of rheumatoid factor titers, and unrelated to the duration of clinical symptoms.

Transthoracic fine needle aspiration is the diagnostic method of choice and will be helpful if it confirms tumor cytology. A benign report, however, may be unreliable since there may be a false negative result in 5% to 20% of neoplastic pulmonary nodules sampled by needle aspiration.¹⁵ This rate may be decreased if an experienced operator is able to obtain specimens from different areas of the lesion.

Treatment of the lung cancer will be dictated by the histology and staging of the tumor. The utility of CT scanning of the mediastinum in staging may be diminished in the rheumatoid patient with pulmonary fibrosis and a lung nodule. It has been demonstrated that mediastinal adenopathy greater than 1 cm in size is not necessarily indicative of mediastinal metastases in this subgroup of patients. The enlarged nodes are often solely due to the underlying autoimmune disease and the chronic inflammatory process.¹⁶ Mediastinoscopy may be considered in the patient with rheumatoid arthritis, a lung nodule, and enlarged nodes in the mediastinum before considering such a patient inoperable.

If the patient is deemed operable, the clinician needs to be aware of the potential for a stormy postoperative course. This has been reported as secondary to the patient's inability to heal due to the exacerbation of underlying rheumatoid pneumonitis and parenchymal damage.¹⁷

In summary, although the occurrence of bronchogenic carcinoma in patients with rheumatoid arthritis is not a frequent occurrence, the

Table 1. Summary of 17 Reported Cases of Rheumatoid Arthritis and Lung Cancer

Gender	10 Males	5 Females	2 unspecified
Serology	13 Seropositive	0 Seronegative	4 unspecified
Pulmonary nodule	17 Present	0 Absent	0 unspecified
Pulmonary Fibrosis	9 Present	4 Absent	4 unspecified
Tobacco use	9 Smokers	5 Nonsmokers	3 unspecified

Table 2. Histopathology of Bronchogenic Carcinoma Occurring with Rheumatoid Arthritis

	Smoker	Nonsmoker	Unknown
Squamous Cell	3	1	
Adenocarcinoma	2	1	
Large Cell	1	0	
Bronchoalveolar	0	1	
Small Cell	1	2	
Type Unspecified	2	0	3

clinician cannot assume that a rheumatoid pulmonary nodule is not being mimicked by a lung neoplasm.¹⁸ It remains the physician's obligation to obtain histologic confirmation of a pulmonary nodule in a patient with rheumatoid arthritis with other necrobiotic nodules.

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The Kentucky Medical Curriculum

A Response to the Call for Educational Reform: A GPEP Report Card

Robert F. Rubeck, PhD; H. David Wilson, MD; Emery A. Wilson, MD; Roy K. Jarecky, EdD;
Phyllis P. Nash, EdD

The resources of an important educational grant provided by the Robert Wood Johnson Foundation, as well as designated local college and medical center funds, provided support for the renewal of the undergraduate medical education program at the University of Kentucky College of Medicine. The fully revised medical curriculum, adapted to changing professional and societal needs and completely in place by the 1994-95 academic year, was influenced by the recommendations of the General Professional Education of the Physician (GPEP) Report, issued by the Association of American Medical Colleges in 1984. This paper details each of the student-centered curricular changes in the context of the GPEP recommendation that it particularly addresses.

Although calls for the reform of American medical education have been long-standing and strident, response has traditionally been slow and idiosyncratic. Recent, rapid, and more consistent reform has occurred in a number of medical schools, but these reforms lack the publicity that might make the experiences useful to others contemplating or in the process of implementing change. The purpose of this paper is to detail one institution's response to the continuing call for essential change in medical education.

At the root of many of the most recent changes in medical education is the General Professional Education of the Physician (GPEP) Report, issued by the Association of American Medical Colleges in 1984.¹ This report, which presented recommendations for restructuring medical education on the basis of a philosophy of general professional education, called for medical curricula to balance the acquisition of medical knowledge with the development of relevant skills, attitudes, and values; to attend to the preparation of

students for the transition to graduate medical education; to adapt the goals of educational programs to changes in the provision of health care; to teach health promotion and disease prevention hand in hand with teaching about disease and treatment; and to demonstrate comprehensive care for individual patients as well as concern for improving health through the efficient use of the facilities of community agencies. In the following paragraphs, each of the recent curricular revisions undertaken by the University of Kentucky College of Medicine (UKCM) will be detailed in the context of the GPEP recommendation that it particularly addresses.

The new, fully revised medical curriculum of UKCM was completely in place by the 1994-95 academic year. The direction of the curriculum is shaped by the tripartite mission of the College.² Because the College is part of the Commonwealth's largest research university, its faculty members have been quick to acknowledge the continuing and rapidly increasing pace of scientific and medical discovery and technological innovation, as well as the continuing avalanche of biomedical knowledge. Because the University of Kentucky Hospital is the primary health care provider for central and eastern Kentucky, including a substantial portion of the Appalachian region, the College's clinical faculty members, in particular, have shown sensitivity to the increasing importance of behavioral, life-style, and environmental factors in determining the quality of health, and to the increasing economic and psychological burdens of chronic illness on families and on the health care system. Because the College is part of an important state-assisted academic medical center, its faculty, students, and administrators are demonstrating a commitment to a medical education that addresses evolving public problems and policies regarding the qual-

Dr Rubeck is Assistant Dean for Educational Development and Research and Academic Computing; Dr H. David Wilson was Associate Dean for Academic Affairs (now Dean, University of North Dakota School of Medicine); Dr Emery A. Wilson is Dean, College of Medicine; Dr Jarecky is Special Consultant to the Dean; and Dr Nash is Vice Chancellor for Academic and Student Affairs at the University of Kentucky Chandler Medical Center, Lexington, KY.

The Kentucky Medical Curriculum

ity, accessibility, and costs of the health care system, as well as those issues most specifically discussed by the GPEP report.

The goals of the Kentucky Medical Curriculum were developed with the emerging needs of both students and faculty in mind. After a prolonged period of educational introspection, a carefully selected reformation steering committee made up of senior faculty members endorsed a set of educational goals that are guiding the development of the new curriculum. Thus the goals of the curriculum address the methods of learning by increasing the use of active modes of learning; emphasizing the principles and concepts fundamental to the understanding of the normal and abnormal functioning of the human organism; refraining from the use of fully detailed handouts for the purpose of providing rote information to be memorized; increasing the use of alternative educational resources; increasing positive regard among and for students; increasing the relevance and retention of fundamental course material; and promoting the skills and attitudes needed for life-long learning. The Kentucky Medical Curriculum was also reorganized to represent a more "rational" approach to subject matter. As may be observed in the charts on the following pages, related content areas are taught in integrated or adjacent blocks of the curriculum so that students become immediately aware of how the intermeshing of disciplines is basic to delivery of competent clinical care and health promotion.

The GPEP Report's recommendations included a call for American medical education to address the need for reform in the methods employed to deliver medical education and promote medical student learning. To respond to this recommendation, the UKCM steering committee charged small faculty working groups with the design of courses that could address the new goals of the curriculum. The initial result was a curriculum that would reduce the number of formal lectures used as a mechanism solely for the transfer of information; increase the use of handouts that depict the organization of subject matter and the purposes for learning; provide meaningful assignments and ample time in the curriculum for independent pursuit; encourage the use of progressive instructional methods and technologies such as computer-assisted instruction, case studies, and reading sets; increase faculty-student contact; and plan for the clinical application of basic science material and the reinforcement of basic science in clinical experiences.

GPEP Conclusion 1, Recommendation 1: *Medical faculties should emphasize the development of skills, values, and attitudes at least to the same extent as the acquisition of knowledge.*

The development of skills, values, and attitudes as coequal with the acquisition of knowledge is, of course, a function of all courses in the curriculum. Nevertheless, particular emphasis on establishing the essentials of appropriate attitudes and values is a function of such courses as "Physicians, Patients and Society" and "Introduction to the Medical Profession," which cover topics ranging from the doctor-patient relationship to the skills needed to palpate the liver. Virtually all clinical departments participate in the presentation of these courses in both the first and second years of a student's experience in the College. In "Physicians, Patients and Society," students use a problem-based learning (PBL) format to consider examples of patients beset by a variety of disease states, with emphasis on the psychosocial and biological aspects of the problems presented. Ethical issues, cost, prevention, and family and community involvement are included for consideration.

"Introduction to the Medical Profession" provides the next step in engendering positive attitudes and values related to patient care by using such vehicles as private medical practice sites, patient interviewing (for enhancement of communication skills), the physical examination, and the rudiments of clinical decision making to intertwine the presentation of technical skills and the ability to empathize with the patient seeking consultation. The demonstration of appropriate attitudes and values is particularly relevant in students' clinical performance in the third and fourth years. Teaching primary care principles in the third year, followed by off-site community-based experiences in the fourth year, emphasizes the provision of care and reflects a foundation of ethical principles and a grasp of the realities of human behavior in response to a complex variety of environmental pressures and conditions.

GPEP Conclusion 1, Recommendation 2: *The level of knowledge and skill students must attain to enter graduate medical education should be more clearly described.*

At UKCM, medical and surgical acting internships in the fourth year provide preparation for graduate medical education. Students learn how to respond to the clinical problems faced by first-year residents and, by so doing, upgrade their

capacity for clinical problem solving. Before experiencing this advanced level of responsibility, third-year students serve in clerkships structured according to incremental learning objectives. Thus, by the time they move on to fourth-year experiences, the students are ready for the more demanding clinical responsibilities of two required acting internships: one in a medical and one in a surgical discipline. During the fourth year, basic science information is reintroduced to ensure that a sophisticated and practical understanding of such information is available for application in the graduate medical education years.

GPEP Conclusion 1, Recommendation 3:

Medical faculties should adapt the general professional education of students to changing demographics and the modifications occurring in the health care system.

The Kentucky Medical Curriculum responds to changes in where, how, and by whom medicine is being practiced by changing the venues for clerkship experiences, by changing the nature of the instructional material (including the cases used for the instructional sessions in required clerkships), and by changing the types of preceptors used for medical student placements. The curriculum has responded to the increasing emphasis on outpatient medicine by significantly increasing the amount of ambulatory education. The increasing need for geriatric medicine has been met by the development of cases, course segments, and required courses related to geriatrics and gerontology. The need for teaching toward communities and minorities has been addressed in part by computerized and PBL cases and also by hands-on medical care in both rural and urban settings. The Dean's Colloquium, a fourth-year course in workshop format, covers a variety of subject matter based on recent trends in health care delivery. Managed care, legal medicine, communication with the media, and ongoing ethical issues in medicine are typical areas for consideration.

GPEP Conclusion 1, Recommendation 4:

Medical education should include an emphasis on the physician's responsibility to work with individual patients and communities to promote health and prevent disease.

The College has a long and distinguished history of regard for and emphasis on issues of preventive medicine and promotion of health. When the College accepted its first class in 1960,

the Department of Community Medicine (now Preventive Medicine and Environmental Health) was already in place. Over the past three decades, providing students with experiences in the reduction of community problems inimical to health and the establishment of programs to enhance health have been paramount goals of the programs in community and preventive medicine.

Preventive medicine topics are now included in the first block of the curriculum as discussion cases in the "Healthy Human" course. Community medicine is an integral part of the "Introduction to the Medical Profession" course, which includes a week spent with a community practitioner. Community medicine is also the focus of all primary care training in years three and four of the curriculum. One-on-one student-patient relationships are emphasized throughout the curriculum, particularly in the primary care-oriented clerkships.

GPEP Conclusion 3, Recommendation 1:

Medical faculties should adopt evaluation methods that identify students who have the ability, drive, and confidence to thrive on independent learning and develop those who do not come with these traits.

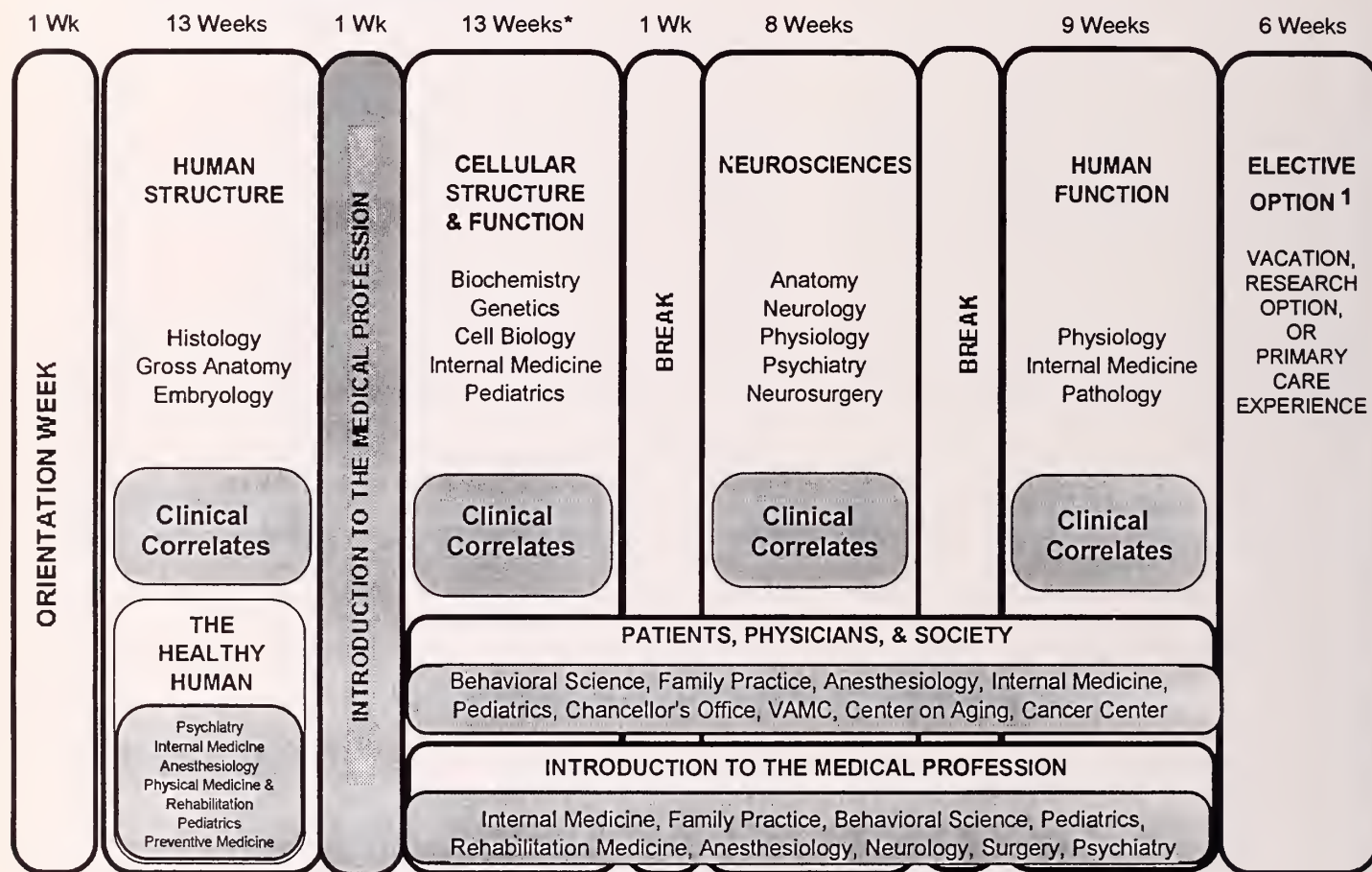
The Kentucky Medical Curriculum uses not one but a mix of instructional techniques to assure that all students will have some sessions in a style that fits their previous experiences. Thus much of the subject matter to be learned is available to students in more than one format. Extensive orientation to instructional methods new to incoming medical students is provided. Because the curriculum provides a variety of instructional techniques, many approaches to evaluation are also used. Besides multiple-choice, practicum, and oral examinations, other techniques include performance-based testing, objective structured clinical examinations (OSCEs), computerized patient-management problems, and standardized patient examinations. The focus of the evaluation program is not only on determining the students' intellectual grasp of biomedical content but also on assessing as closely as possible their capacity for efficient problem solving and their understanding of professionalism in patient interactions. All of this means a determination about the quality of the student's total interaction with the patient rather than a narrow focus on the accuracy of recall of factual content. The curriculum builds toward a fourth year that emphasizes students' responsibility for patient care.

The Kentucky Medical Curriculum

University of Kentucky College of Medicine

1996-97

YEAR 1: 46 Weeks Required Curriculum



Blueprint for a Medical Curriculum: The Kentucky Medical Curriculum. (Graphs, Years 1 through 4)

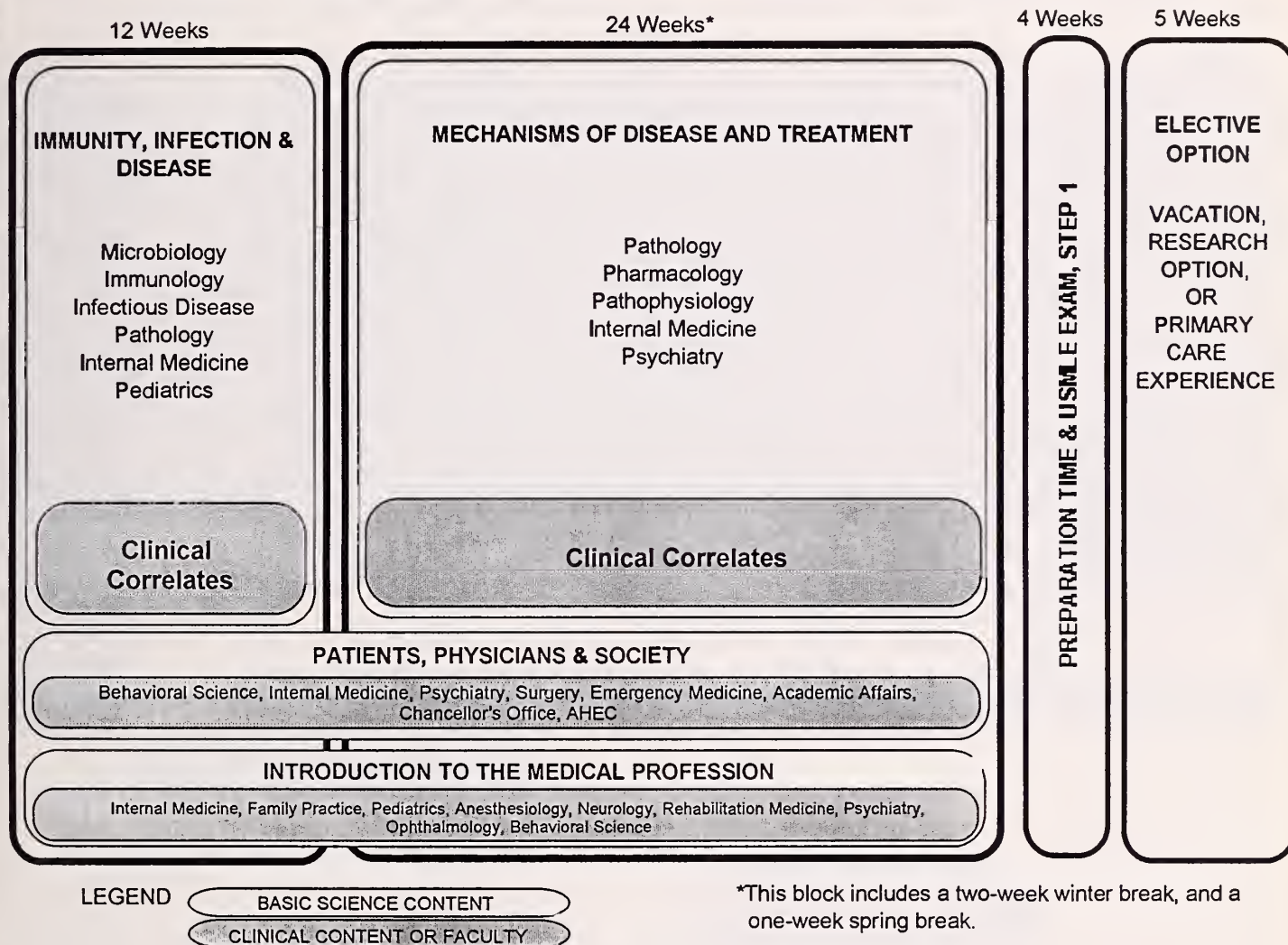
GPEP Conclusion 3, Recommendation 2: Medical faculties should encourage students to learn independently by setting attainable educational objectives and providing sufficient unscheduled time for that pursuit.

The Kentucky Medical Curriculum appropriately reassigns the primary responsibility for learning to the students. Most major courses are offered sequentially, one block at a time, to minimize the competition for students' time and attention that is often stimulated by multiple, concurrent course offerings. Several large blocks of time are avail-

able each week during which students can complete self-study assignments. The widespread use of PBL in both basic science courses and clinical clerkships requires students to seek relevant information on their own and particularly to use the expertise of a host of health care personnel. Also, clinical experiences are distributed across a variety of sites, thus broadening the students' independent perspectives with respect to the resources available for learning about and solving patient care problems.

University of Kentucky College of Medicine

YEAR 2 36 Weeks Required Curriculum



GPEP Conclusion 3, Recommendation 3: Medical faculties should examine the number of lecture hours in the curriculum and consider major reductions as well as instructional replacements.

The Kentucky Medical Curriculum has reduced the proportion of instruction that is done both in class and from a teaching-centered perspective. The number of lectures per week has been limited, and formal large-group presentations are restricted to the morning hours. Interactive audience response technology has been introduced to help make the remaining lectures more interactive. The development of computer-

based formats for presentation of lecture material has freed both lecturer and learner from some of the tyranny caused by the inflexibility of time during lectures.

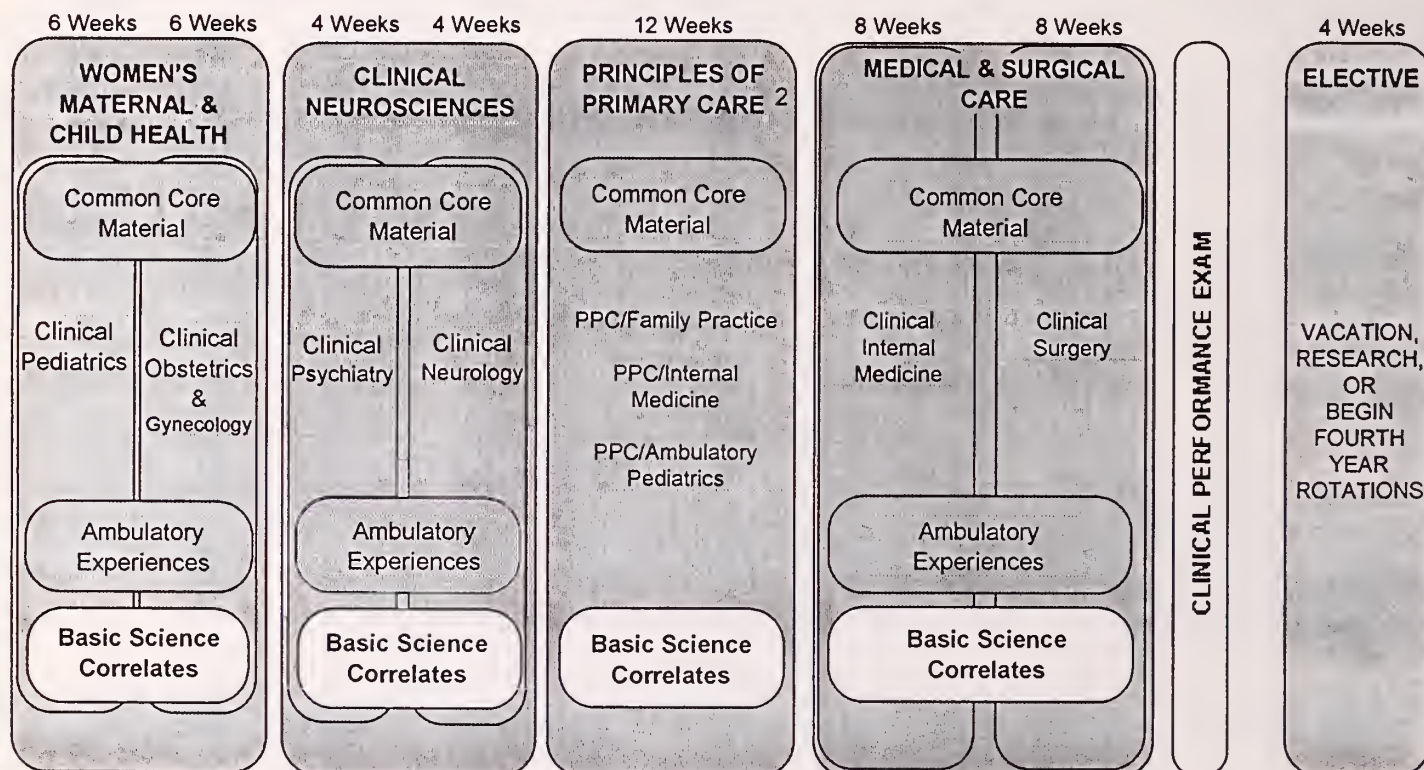
GPEP Conclusion 3, Recommendation 4: The development of independent learning and problem solving skills should be assessed by evaluation methods appropriate to judge student's abilities to analyze and solve problems, not by a test of their ability to recall memorized information.

As noted under GPEP Conclusion 3, Recommendation 1, the evaluation procedures used in

The Kentucky Medical Curriculum

University of Kentucky College of Medicine

YEAR 3 49 Weeks Required Curriculum



LEGEND:

BASIC SCIENCE CONTENT

CLINICAL CONTENT OR FACULTY

NOTES: 2. Two four-week rotations taken in Lexington, and one four-week rotation taken at an AHEC site.

several courses now include a broader array of evaluation instruments than did those of the traditional curriculum. Some courses are using essay writing to evaluate students' critical thinking skills. Several courses and clerkships are using standardized patient examiners to measure the development of students' clinical skills. A few clerkships are using computer-based patient simulations to assess the development of problem-solving skills resulting from clerkship experiences. The College uses a clinical performance examination (CPX) to measure the accumulation of clinical skills.

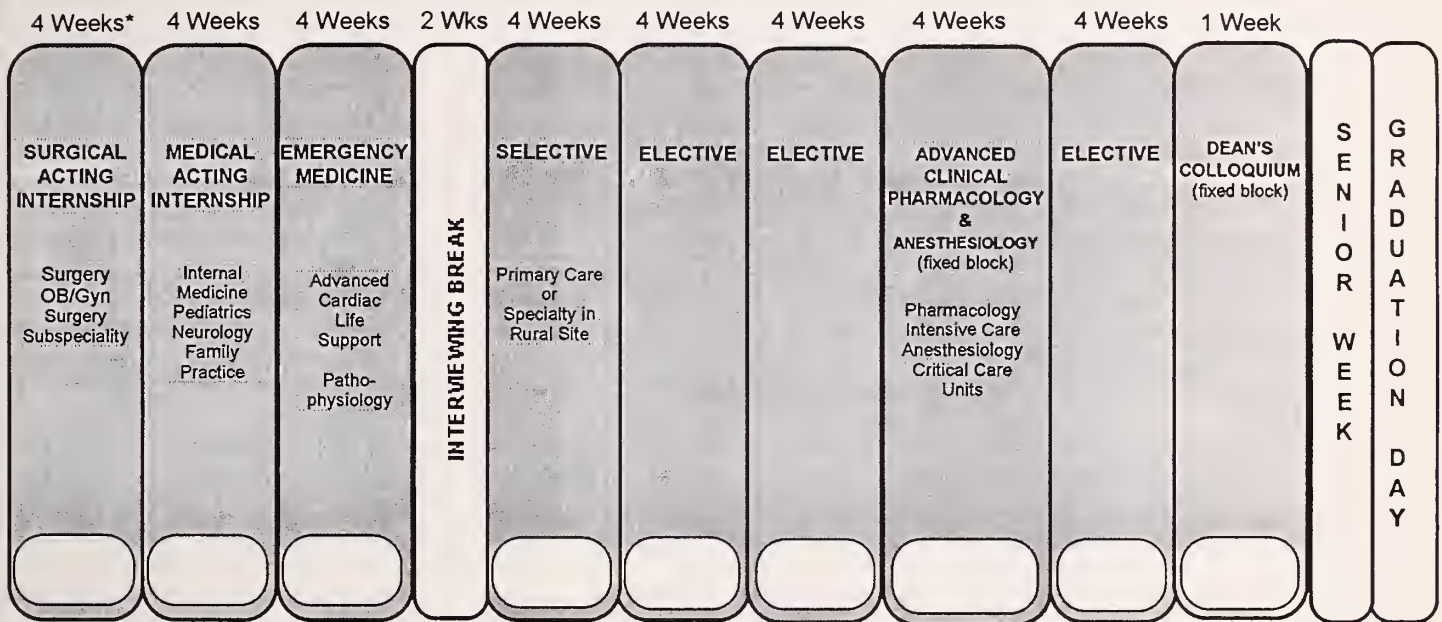
GPEP Conclusion 3, Recommendation 5: Medical faculties should offer educational experiences that require students to be independent learners and problem solvers, rather than passive recipients of information.

All major courses use a variety of techniques such as lecture, small groups, and computer-based learning. Many of these courses use some form of problem-based learning. Faculty development workshops on tutoring techniques and PBL case development are offered regularly.

GPEP Conclusion 3, Recommendation 6: Medical schools should designate an academic

University of Kentucky College of Medicine

YEAR 4 33 Weeks Required Curriculum - The clerkship sequence is variable except for the two fixed blocks and interviewing break.



LEGEND:

BASIC SCIENCE CONTENT

CLINICAL CONTENT OR FACULTY

* This first block is preceded by USMLE Step 2.

unit for institutional leadership in the application of information sciences and computer technology to general professional preparation.

The College has established the Academic Computing in Medical Education (ACME) support group to offer computer facilities, software acquisition, and training for students. Faculty training in academic computing is offered in conjunction with the faculty Resource Center for Medical Education. Most courses have some computerized instructional component, and many make extensive use of in-house software development facilities. Several courses provide students with lecture material in the form of computer-based slides for individual study.

GPEP Conclusion 4, Recommendation 1:
Medical faculties should specify the clinical knowl-

edge, skills, values and attitudes that students should develop in their general professional preparation.

Course faculties and course design task forces have been responsible for the explication of course content and instructional goals to this point. Now cross-course curriculum subcommittees are determining the aggregate learning that should occur in any given year of the curriculum.

GPEP Conclusion 4, Recommendation 2:
Medical faculties should describe and provide the clinical settings appropriate for required clinical clerkships.

Clinical education begins in year one of the curriculum, with a week in the office of a primary care practitioner, and continues throughout all four years. Clinical education sites include inpa-

The Kentucky Medical Curriculum

tient services, outpatient primary care clinics, hospices, rehabilitation facilities, geriatric facilities, public health clinics, rural medical facilities, and extramural (ie, outside of Kentucky) educational experiences. Regardless of site, progressive increase in clinical activity and responsibility during each year is assured by the structure of the curriculum.

GPEP Conclusion 4, Recommendation 3: *Those responsible for clinical education should have adequate time to guide and supervise medical students during clerkships.*

The instructional schedule for all clinical clerkships has been revised to reduce the amount of pure clinical apprenticeship and increase the formal instruction of students in workshops, small-group learning sessions, and directed independent study.

GPEP Conclusion 4, Recommendation 4: *Medical faculties should develop and adopt explicit criteria for the systemic evaluation of students' clinical performance.*

Three required clerkships use standardized patients for the assessment of specific clinical skills. Educational site visits have been used to train a number of interested clinical faculty members in the development and use of CPXs. A set of core clinical performances common across clerkships has been developed to guide the implementation of a CPX to take place before graduation.

GPEP Conclusion 4, Recommendation 5: *Medical faculties should encourage their students to concentrate their elective programs on the advancement of their general professional education rather than on the pursuit of a residency position.*

The fourth year is designed to enable students to broaden their perspective of medical practice through experience in a variety of clinical settings; to explore special interests and build on demonstrated strengths; to expand their appreciation of the scientific basis of clinical medicine; to eliminate any deficiencies or weaknesses in their general professional preparation; and to achieve a smooth continuity between medical school and post-graduate learning. Besides the educational objectives implied by these goals, it is clear that the emphasis is on a strong basic educational program rather than primarily on securing a residency position. The schedule allows for only two fourth-year electives with limitations

on how many may be with one department or at a particular extramural site. Many students spend elective time enhancing basic clinical skills in medicine, surgery, or both. The Dean's Colloquium at the end of the year reiterates those values basic to the appropriate practice of medicine, particularly how such values may be demonstrated in realistic clinical care situations.

GPEP Conclusion 5, Recommendation 1: *Medical school deans should identify and designate an interdisciplinary organization of faculty members to formulate a coherent and comprehensive educational program and select instructional and evaluation methods to be used.*

A faculty course development task force was formed for each primary component of the curriculum outlined by the Steering Committee. Task force members were selected on the basis of their previous involvement in course planning, their current individual interest, and their desired course contribution. In all, 21 faculty task forces reviewed, revised, and fleshed out the skeletal curriculum with courses, clerkships, selectives, and electives that maintain an overall institutional philosophy of education. College-wide retreats were used to communicate with faculty members about impending changes, plans being generated, and new points of view. During the years since the Kentucky Medical Curriculum was implemented, the task-force approach and individual consultations with the faculty course director have continued. Detailed written formulations of course presentations and faculty teaching portfolios are considered essential to curriculum vitality and are reviewed regularly by the Dean's Office and the departmental chairs.

GPEP Conclusion 5, Recommendation 2: *The educational program for medical students should have a defined budget that provides resources for its conduct.*

The resources of an important educational grant provided by the Robert Wood Johnson Foundation, as well as designated local college and medical center funds, were totally dedicated to the renewal of the undergraduate medical education program. Of critical importance is the continuing financial support provided by the Dean's office to maintain and enhance the variety of approaches to learning that are the foundation of the Kentucky Medical Curriculum. More stable funding for continuation of the improvements in the educational program has been sought from

the state legislature in a biennial budget request. An additional separate budget has been developed for the educational services that support student affairs, admissions, and academic affairs administration. Central educational funds are administered by the associate dean for academic affairs.

GPEP Conclusion 5, Recommendation 3: *Faculty members should have time and opportunity to establish a mentor relationship with individual students.*

The widespread use of small-group instruction in the curriculum has helped with the personalization of the educational program for students by providing a two-year precursor in the "Physician, Patient, and Society" course for mentorships that evolve and flower particularly during the clinical years. Half of our graduates enter generalist specialties not only because of their original interest in the specialty but also because of early contact with generalist faculty members in the Kentucky Medical Curriculum, particularly family practice physicians and community physicians at Area Health Education Center sites.

GPEP Conclusion 5, Recommendation 4: *Medical schools should establish programs to assist faculty members to expand their teaching capabilities beyond their specialized fields to encompass as much of the full range of general professional education as possible.*

The Resource Center for Medical Education comprises a group of faculty members who direct the College's faculty development activities. Training workshops have thus far introduced more than 350 faculty members to problem-based learning and academic computing.

Faculty involvement on teams writing cases for PBL sessions helps with cross-fertilization of content in those cases. Teaching in PBL sessions and other small-group formats strengthens each faculty member's grasp of the most general material in medical education. The college's new Master Teacher Program provides recognition and incentives for faculty advancement.

GPEP Conclusion 5, Recommendation 5: *Medical schools should provide support and guidance to enhance the personal development of each medical student.*

In many respects, the personal development of each medical student depends on a strong Office of Education (now the Office of Academic

Affairs, OAA). The philosophy of the OAA at the College is to enable students to improve their problem-solving skills as they advance through the curriculum. The OAA does not simply administer "services." Rather, it perceives every interaction with a student as an opportunity to enhance that student's personal and professional development. Whether discussing financial aid, academic problems, interpersonal difficulties, or specialty selection, the focus is always on enabling students to achieve an optimal solution and to fully appreciate the process through which the solution was achieved. In this way, problem-solving skills, whether learned via the curriculum or tangentially to it, may be applied wherever appropriate.

GPEP Conclusion 5, Recommendation 6: *By their own actions deans and department chairs would elevate the status of general professional education of medical students and assure faculty members that their contributions will receive appropriate recognition.*

The Dean and the departmental chairs have been kept informed of every aspect of the curricular reform and have provided leadership as needed.

Concluding Statement

Although no medical school can guarantee that it will have a significant impact on the myriad of undergraduate educational programs from which admitted applicants arrive, it is certainly possible for a medical school to follow the GPEP precepts and to ensure that it effectively presents a general professional education during the undergraduate medical school years. The GPEP Report calls for medical graduates dedicated "to work, to rationality, to science and to serving the greater society,"¹ as well as to a mastery of the basics of biomedical information and clinical skills. Certainly, one of the purposes of the UKCM's curricular revision was to respond to the GPEP recommendations. The process set in place to formulate a curriculum consonant with GPEP goals is fundamentally an experience in behavioral change: to enable medical students (1) to visualize faculty members as potential mentors, (2) to understand the practical meaning of such words and phrases as ethical sensitivity, moral integrity, equanimity, humility, and self-knowledge in relation to the demands of patient care, and (3) to recognize that the realities of the need for life-long learning

The Kentucky Medical Curriculum

require an educational experience that identifies and enhances the values implied and expressed in the day-to-day routine of classroom and clerkship. By involving medical students ever more tightly in assuming personal responsibility for learning, and by presenting patients from the very beginning as individual human beings, we have attempted to establish those values and attitudes that are typical of the mature, broadly educated individual.

The matter of behavioral change is just as much an issue for faculty members as it is for students. Faculty members provide the critical role models that may most expeditiously affect students' behavior. Thus notions such as science as a way of thinking, rational assessment of data, sensitivity to patients, grasp of cultural nuances that modify a patient's thought processes and behavior, and many more can be successfully conveyed if faculty members see their role as considerably more than simply purveying technical information.

The Kentucky curriculum emphasizes problem solving, small-group activity, diversity in clinical care settings, and an approach to patient care that requires input not only from the patient and the patient's family but also from a score of professional sources. The College's goal is a unified and sophisticated approach to care that underscores the values stressed in the GPEP report. Both fac-

ulty members and students recognize that their common task is one in which the students have the responsibility for learning and the faculty have the responsibility for providing the guidance necessary to ensure that learning occurs.

Keeping the enterprise moving forward is not easy. Faculty are beset by many requirements for their time other than teaching and guiding students. For their part, students are always under pressure to "know enough." Nevertheless, it is our experience that a person-centered and problem-centered curriculum produces students who are truly capable of dealing professionally, efficiently, and humanely with the complexities of patient care and patient education. Most importantly, the students' level of altruism continues to be high and not diluted by the "business" of medicine.

The GPEP report has provided the impetus for many medical schools to recast their curricula. As one of the many, we endorse the practical and philosophical wisdom of that report.

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Criticism and Medicine

The recent controversy swirling around the Kentucky Supreme Court election speaks to that balance between constructive criticism and the violation of ethical standards. That all of us take challenges to what we are doing strengthens our integrity by exposing flaws and by reinforcing our correctness.

For medicine the insertion of gag rules by the managed care industry, the positioning of medical colleagues to jury over our practices, and the increasing public wars that some medical staffs and their physicians start are disturbing the comfortable and critical interchange that used to be common place. Whether the setting was the doctor's lounge or the more formal staff conference room, the participants pledged to listen and talk, on balance for the purpose of finding the truth. Sometimes corrections had to be made, some judgments questioned and reconsidered, some staff changes pursued, but for the most part in the spirit of bringing better medical care to the patients. Adversarial events typically stayed in the courts.

With the advent of managed care came a useful introspection about how efficiently and effectively we did our medicine. That microscopic view ferreted out many costly and needless procedures and practices. However, with the remodeling came the destruction of some precious traditions. No longer could the support of all your colleagues be expected, if part of the arrangements with the carriers required excluding some physicians from the opportunity to participate. What used to be a form of the survival of the fittest, that the successful physicians had patients gravitate to them, and the less skilled

"What the gatekeeper has to do, and what the people on both sides of the gate have to also do, should be worked out by us, not by those who would place us opposed to one another."

physicians changed their working arrangements, dissipated into a more sectorized division of patients. Numbers of medical care consumers substituted for numbers of patients. Injecting the words "consumer" and "provider" into the medical jargon put the physician in a quite different role.

A good intentioned medical director, no matter how hard the effort at fairness, expects to pass judgments regularly on his fellow physicians. Committees sanctioned to study practices have to reward and punish, not really teach and evolve a colleague's way of doing things. Competition, already inherent in the medical educational process, helped before to filter the profession, eliminate some who really should be doing other things, and clarify what can be done to improve. That good thing seems lately to be eroded by legal turf battles, by challenges to medical staffs, by privilege struggles, and by a creeping reality that doctors are fighting more among themselves than before. Certainly bickering in the past occurred even in the most serene medical environments, but that took the form of respectful disagreement, not bellicose public interchange. We

expect to find some colleagues at fault, to have failed, to lose competence, to misrepresent, and to have crossed some ethical line. Our record of policing ourselves stands the test of time, with so many difficult problems constructively solved. That spirit incited the proper disposal of what had to be done, with the knowledge that these actions were taken for good reason. Lately, as our ranks have swelled, as the insurance industry and government play an increasing role in the management of medicine, this collegiality has dimmed and more fractionation has substituted.

What should we do now? Remember that medicine is an honorable profession. Work with your fellow physicians with respect, that we all should use our differences constructively. That distinguishes us from the antagonistic professions, where battle is the norm. Rather than that model, should we not try to regain that strength that comes from working together. Should we not resist that tendency to criticize each other with little merit, with the transient result of some advantage being gained. With the outsiders touching us daily over the phone, over the "bulletins," and over financial muscle flexing, we need to respect our differences, negotiate our issues, and take care of each other again in a more benevolent way. What the gatekeeper has to do, and what the people on both sides of the gate have to also do, should be worked out by us, not by those who would place us opposed to one another. Construct our criticism to benefit both sides, not to destroy what good we already have.

Stephen Z. Smith, MD

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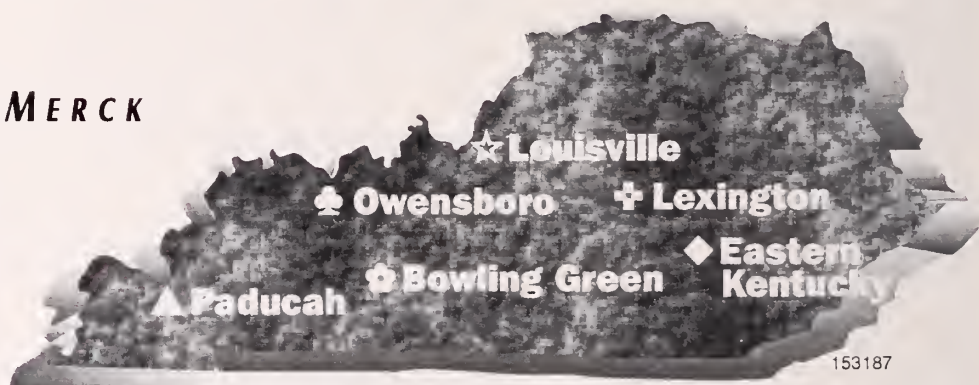


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Morning Has Broken



Ruth Ryan

As we rocket toward the 21st century, let's keep in mind that with the resources of good health, knowledge, and experience, we have the capacity to meet every new challenge presented to us. Using those heavenly gifts and the legacy of our parents and teachers, we can hurdle all obstacles and touch in a positive manner the lives of all with whom we come in contact.

The concept of our remarkable resilience is best expressed by Eleanor Farjeon in the delightful poem "Morning Has Broken," most often heard sung to the tune of an old Gaelic melody.

*Morning has broken like the first morning,
Blackbird has spoken like the first bird.
Praise for the singing!
Praise for the morning!
Praise for them springing fresh from the Word!*

*Sweet the rain's new fall,
Sun-lit from heaven,
Like the first dew-fall on the first grass.
Praise for the sweetness of the wet garden,
Sprung in completeness where his feet pass.*

*Mine is the sunlight!
Mine is the morning
Born of the one light Eden saw play!
Praise with elation,
Praise every morning,
God's recreation of the new day!*

HAPPY NEW YEAR to all KMA physicians, families, and staff!

Ruth Ryan
KMAA President

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William T. Applegate Named KMA Executive Vice President

William T. Applegate has been elevated to Chief Executive Officer of the Kentucky Medical Association. The Board of Trustees has named him Executive Vice President to succeed Robert G. Cox who retired January 2, 1997.

Applegate is a Louisville native and received a BA degree from the University of Louisville in 1966. He joined the Association as an Administrative Assistant in 1968, became Executive Assistant six months later, and has served as Deputy Executive Vice President since 1972.

He is a Past President of the Professional Convention Management Association, Secretary of the Rural Kentucky Medical Scholarship Fund, a member of the American Association of Medical Society Executives, and an Affiliate Member of the American Medical Association.

"I am enthusiastic about this increased opportunity to serve Kentucky physicians," says Applegate, who began his CEO duties on January 2. "This Association has a rich history of service to Kentucky physicians, patients, and policymakers, and I look forward to working with KMA leadership and members during these very challenging times for physicians."

The Board is confident that Kentucky physicians will benefit from Applegate's leadership and experience in the healthcare realm.

Bill's interests outside his profession include music, traveling, sports cars, and of course, his family. He and his wife Susie reside in Louisville. They have a daughter, Amanda, who is a freshman at Bellarmine College in Louisville.



Patrick T. Padgett and Brett A. Leichhardt Join KMA Staff

Patrick T. Padgett has joined the KMA staff as Director of Governmental Relations and Staff Counsel. He is serving the Association in various capacities, is assisting in KMA's legislative activities, and is staffing several committees within the KMA structure.

A native Kentuckian, Padgett is a University of Kentucky alumni, having earned a Bachelor of Arts degree in political science in 1987, and a Juris Doctorate in 1990 from the University.

He comes to KMA following several years as General Counsel for the Naval Security Group Command in Washington, DC, and Defense Counsel for the Naval Legal Service Office in Oak Harbor, Washington.



Brett A. Leichhardt of Louisville joined the KMA staff in October 1996.

A native of Louisville, Leichhardt graduated from Bowling Green High School in Bowling Green, Kentucky, and earned a Bachelor of Arts degree in Communications from the University of Kentucky.

He was previously Regional Representative in the states of North Carolina, Tennessee, and Illinois for Premier Management/The Londen Insurance Group.

In addition to his administrative duties, Leichhardt will be staffing various committees and will be working in the legislative and public/patient relations arena.



PEOPLE

J. David Richardson, MD, University of Louisville Department of Surgery, was recently elected vice chair-elect of the American Board of Surgery. He will assume the duties of vice chair July 1, 1997, and those of chair July 1, 1998.

Brett Coldiron, MD, FACP, was selected as an "Outstanding Young Physician" by the *Ohio Medicine* magazine. Each year *Ohio Medicine* selects eight physicians in the state of Ohio, who are 40 years old or under, in recognition for their significant contributions to their profession and their communities. Dr Coldiron practices in Cincinnati and specializes in the treatment of problem skin cancers. He and his wife, **Lana Long, MD**, live in Kenton Hills, KY.

Martin Mark, MD, was recently elected as Governor to represent the state of Kentucky on the National Board of Governors of the American College of Gastroenterology. Dr Mark is in private practice in Gastroenterology with **Edward Adler, MD**, and **Gerard Siciliano, MD**.

UPDATES

Laboratory Accreditation-KMA Endorses COLA

As a provision of the federal Clinical Laboratory Improvement Act all laboratories must be certified or accredited to perform any clinical procedures. In September the House of Delegates endorsed the Commission on Laboratory Accreditation as an agent for this qualification.

COLA is a nonprofit physician-directed organization which provides

a program of voluntary education consultation and accreditation. COLA was founded by the American Academy of Family Physicians, American Medical Association, American Society of Internal Medicine and the College of American Pathologists as a private sector alternative to CLIA inspection.

According to the Kentucky Division of Licensing and Regulation, accreditation by COLA and the College of American Pathologists will satisfy CLIA requirements for physician office labs and others. The state performs CLIA laboratory certification reviews on behalf of the federal government.

Information on the COLA Laboratory Accreditation program and its other services is available by calling COLA at 800/981-9883.

AMA Reports Solid Gains For Medicine and Patients

The 104th Congress adjourned for 1996 after concluding its work on a variety of appropriation bills and several other outstanding issues. The AMA reported that the legislative and regulatory successes during the last 2 years make this one of the most meaningful. These include:

Antitrust Relief:

HR 2925 — the Antitrust Health Care Advancement Act of 1996 — the Federal Trade Commission on August 28th issued their "Statements of Antitrust Enforcement Policy in Health Care." The enactment of these new guidelines will provide physicians with a rich source of tools to form different kinds of networks in order to respond to the many changes which have taken place in the health care marketplace.

Federal Health Insurance Reforms:

The Kassebaum-Kennedy health insurance reform law extends to patients portable insurance coverage, guaranteed issue for small businesses, places limits on restrictions based

upon preexisting medical conditions and includes a demonstration project to determine the effectiveness of Medical Savings Accounts (MSAs).

Fraud and Abuse:

New tools are available to assist government agencies to catch truly fraudulent health care providers while ensuring that providers who make innocent mistakes or billing errors will not be unfairly punished. Criminal allegations must be proven to be knowing and willful violations of the law. Similar standards apply to the imposition of civil monetary penalties. In addition, the AMA won the right for physicians to obtain binding advisory opinions to determine in advance whether or not a particular business arrangement is in compliance with these new, complex fraud and abuse statutes.

Advisory Commission on Consumer Protection and Quality:

The AMA has fiercely pursued an agenda which heightens governmental awareness of the need for patient protections in the new era of managed care. President Clinton announced the formation of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The President's charge to this Commission is for it to assess changes occurring in the health care system and "recommend measures that may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system."

Mental Health Insurance

Coverage Parity:

Requires that aggregate and annual payment limits on insurance policies be the same for mental and physical illnesses for all health plans that provide mental health benefits.

Banning "Drive-through Deliveries":

Agreed to legislation which will prohibit the insurance company practice known as "drive-through deliveries."

Kentucky's WIC Program Available to Member Physicians

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has been in existence over 20 years. WIC is intended to be an adjunct to medical care by providing nutrition education and special foods to women who are pregnant, breastfeeding or postpartum, and infants and children through age 4.

WIC is also for low income working families and is serving 120,000 Kentuckians each month. While WIC may be best known for providing infant formula, WIC supports breastfeeding and also issues nutritious foods such as milk, peanut butter, juice, and cereals low in sugar content. WIC service sites currently include health departments, schools, primary care centers, and hospitals.

The Kentucky WIC Program wants to work cooperatively with physicians for the maximum benefit of patients. If physicians have questions or concerns about the WIC program, contact either your local health department or **Steve Davis, MD**, Director of Maternal and Child Health at 502/564-4830.

"Keep Moving for Life"

The American Academy of Orthopaedic Surgeons has launched a national public education program, "Keep Moving for Life." The program encourages people 55 and older, even those with arthritis, osteoporosis, and other chronic conditions of bones and joints, to engage in a balanced program of moderate physical activity for 30 minutes a day.

Beneficial activity could be brisk walking and riding a bicycle, or it could be daily living activities such as gardening or washing a car. The activity should be at least 30 minutes a day, but that could be divided into shorter time periods. It all counts.

A free brochure may be obtained by calling 800/824-BONES.

Guillain-Barre Syndrome Support Person Available in Kentucky

The Guillain-Barre Syndrome Foundation International, a nonprofit organization located in Wynnwood, Pennsylvania, was founded in 1980 by Robert and Estelle Benson to assist victims of this rare, paralyzing, potentially catastrophic disease of the peripheral nerves. There is now a contact person in Kentucky — Anne Meyer, a registered nurse. Ms Myer is agreeable to contacting any Guillain-Barre patient and/or their family in the state of Kentucky. You may contact her at 4903 Grant Avenue, Louisville 40214, phone 502/367-4876.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

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1339 N Race St, Glasgow 42414
1990, U of Louisville

Boyle

Marco V Baquero, MD —P
PO Box 1168, Danville 40423-1168
1976, Central U of Quito, Ecuador
David S. Overstreet, MD —IM
459 Martin Luther King Blvd, Danville 40422
1989, U of Louisville

Campbell

Mina C. Kalfas, MD —FP
94 E Lickert Pike, Alexandria 41001
1993, U of Kentucky

Calloway

Julie C. Christopher, MD —IM
300 S 8th St Ste 482-W, Murray 42071
1985, U of Louisville

Carroll

Elizabeth A. Hollenback-Ellinas, MD —AN
309 11th St, Carrollton 41008
1992, U of Chicago

Christian

Robert Burgess Bressler, MD —IM
1717 High St Ste 2C, Hopkinsville 42240
1977, Duke
Donald L. Spicer, MD —U
124 James Lyn Dr, Hopkinsville 42240
1990, U of Kentucky

Daviess

Artis P. Truett, III, MD —D
1203 Center St, Owensboro 42303
1988, Duke

Fayette

Colby P. Atkins, MD —S
1401 Harrodsburg Rd Ste C100, Lexington 40504
1984, Baylor, Houston
Michael R. Balm, MD —N
1725 Harrodsburg Rd Ste M, Lexington 40504
1991, U of Minnesota
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717 Widener Ct, Lexington 40504
1993, U of Louisville
Nancy A. Bishof, MD —PD
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1984, Rush
Leslie D. Boyd, MD —IM
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1988, U of Oklahoma
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744 Andover Village Dr, Lexington 40509-1905
1991, Medical College of VA
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1992, U of Arizona

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40515-1807

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40515

1987, U of Texas, Dallas

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1141 Parklawn Dr, Lexington 40517
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1401 Harrodsburg Rd Ste B485,
Lexington 40504

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4301 Watertrace Ct, Lexington 40515
1990, U of Louisville

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Lexington 40504

1974, U of Kentucky

Susan E. Neil, MD —FP
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40515

1987, Medical U of South Carolina

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1979, Rush

G. Michael Pittman, MD —FP
4864 Bud Ln, Lexington 40514-1416
1993, U of Kentucky

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UKMC Dept of Pediatrics, Lexington
40536-0084

1985, WV Sch of Osteopathic Med

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247 S Ashland, Lexington 40502
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1403 State Route 940, Mayfield 42066-
4791

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Henry

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PO Box 125, Eminence 40019
1986, U of Louisville

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205 Abbott Ln, Madisonville 42431-
8634

1982, U of Maryland

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200 Clinic Dr, Madisonville 42431
1980, Medical U of South Carolina

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1980, Kansas City Col of Osteopathy

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200 Clinic Dr, Madisonville 42431
1967, Ohio Medical U

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40205-2657

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40291

1989, CMDNJ, Rutgers

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40202

1985, U of California, Irvine

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2156

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Edgewood 41017

1993, U of Tennessee

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Edgewood 41017

1984, U of Cincinnati

Lincoln

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1982, Loma Linda

McCracken

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8887

1988, Chingleput, India

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7009

1989, Georgetown

Meade

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502 Bypass Rd, Brandenburg 40108-
1702

1993, U of Kentucky

Montgomery

Ray B. Terrell, MD —U
250 Foxglove Dr Ste 5, Mount Sterling
40353-9770

1990, U of Kentucky

Pike

Gary D. Williams, MD —IM
PO Box 2288, Pikeville 41502
1993, U of Louisville

Scott

Cedric Craig, MD —GP
PO Box 179, Stamping Ground 40379
1963, U of Sheffield, England

Henry R. Preston, MD —FP
1140 Lexington Rd, Georgetown 40324
1992, Marshall U

Warren

Bryan K. Botner, MD —PM
790 Grider Pond Rd, Bowling Green
42104

1989, U of Louisville

Randy A. McCool, MD —OBG
1509 Neptune Way, Bowling Green
42102

1987, Loyola. Maywood

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Nga Thi Le, MD	—FP
David T. Meadows, MD	—FP
Timothy Murphy, MD	—FP
Mary S. Shields, MD	—FP
Sherryl J. Tombouljian, MD	—FP

Fayette

Michele A. Kettles, MD	—PM
-------------------------------	------------

Jefferson

V Rao Bollu, MD	—AN
Stephen A. Cawood, MD	—EM
Benjamin D. Tanner, MD	—S

DEATHS**Arthur H. Keeney, MD**
Louisville
1920-1996

Arthur H. Keeney, MD, a nationally-known ophthalmologist and former dean of the University of Louisville School of Medicine, died October 1, 1996. During his career, he served on several national safety boards, contributing to the development of plastic eyeglasses, to eye testing standards for auto and truck drivers, to the introduction of safety belts and to safer windshields. On October 12, Dr Keeney was scheduled to receive the Caritas Foundation's first Physician of the Year award for a significant medical contribution and "unselfish humanitarian service to the community." He was a 1944 graduate of the University of Louisville School of Medicine and an active member of KMA.

Albert H. Meinke, III, MD
Lexington
1946-1996

Albert H. Meinke, III, MD, a general surgeon, died October 8, 1996. Dr Meinke was a 1973 graduate of the University of Michigan Medical School and an active member of KMA.

Claude E. Cummins, Jr, MD
Washington
1927-1996

Claude E. Cummins, Jr, MD, a family practitioner, died October 9, 1996. A 1955 graduate of the University of Louisville School of Medicine, Dr Cummins was an active member of KMA.

Edward S. Wilson, MD
Pineville
1910-1996

Edward S. Wilson, MD, a retired family practitioner, died October 28, 1996. A 1935 graduate of the University of Louisville School of Medicine, Dr. Wilson was a life member of KMA.

William H. Brown, MD
Irvington
1905-1996

William H. Brown, MD, a retired general practitioner, died November 11, 1996. Dr Brown was a 1937 graduate of the University of Louisville School of Medicine and a life member of KMA.

Clarence F. Sullivan, MD
Paducah
1921-1996

Clarence F. Sullivan, MD, a retired internist, died November 18, 1996. A 1951 graduate of the University of Louisville School of Medicine, Dr Sullivan was a life member of KMA.

Alex M. Forrester, MD
Louisville
1910-1996

Alex M. Forrester, MD, a retired otolaryngologist, died November 22, 1996. Dr Forrester was a 1935

graduate of the University of Louisville School of Medicine and was a life member of KMA.

David H. Leeper, MD
Adams, TN
1939-1996

David H. Leeper, MD, a psychiatrist, died November 26, 1996. A 1966 graduate of the University of Kentucky College of Medicine, Dr Leeper was an associate member of KMA.

RATES AND DATA

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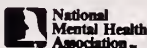
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VOLUME 95, NUMBER 2

FEBRUARY 1997

KENTUCKY MEDICAL



COVER: Poisonings occur all too often and are the fourth most common cause of death during childhood. Estimates are that between 5 and 10 million childhood poisonings occur each year in the US. Approximately 90% of these incidents occur at home, and most are due to accidental ingestion. This month's cover story reports the accidental home ingestion of lithium by a child and reviews fundamentals of its harmful effects and treatment.

Artwork by Lee Wade of Eminence, KY

COVER STORY	Acute Accidental Lithium Poisoning in a Child <i>Michael W. Simon, MD, PhD, FAAP</i>	59
SCIENTIFIC	Spontaneous Rupture of Abdominal Aortic Aneurysms in Patients With Non-Related Blunt Traumatic Injuries <i>Eddy H. Carrillo, MD; Enrique Ginzberg, MD; Nicholas Namias, MD; Larry Martin, MD</i>	64
	The Surgical Implications of Primary Hypercoagulable States <i>Thomas M. Bergamini, MD; J. David Richardson, MD</i>	67
EDITORIAL	Keep in Touch <i>Daniel W. Varga, MD</i>	75
ASSOCIATION	Monitoring Medicine KMA Board of Trustees December Meeting News	55 80 82
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Book Review Continuing Education Information for Authors	53 86 78 77 76 61

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Vice Speaker

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Time Out for Reflection

While it is still early in the year, this is a good time to critique our progress on the varied issues we have faced during the past year, many of which are still very much on the 1997 agenda. All of us who are working in the health care field recognize that change is inevitable. We have, however, the opportunity to become informed on the issues, participate in the political process and become catalysts for change to provide a more inclusive health care environment which is more accessible and affordable to all.

All of us in leadership at KMA seek and need the advice and counsel of all of our membership in order to build consensus on critical issues. For example, there is no greater test of our capacity to lead than the development of a long range strategy for a managed care organization on a state wide basis. Your leadership is diligently at work on this task, but has not yet reached a comfort level on a final plan. We must avoid the temptation of coming up with a quick fix and miss opportunities in our long range planning. We must keep all of our options open. We are interested in your continued feedback.

We all recognize that the proliferation of information systems continues. This presents physicians with great opportunities as well as many challenges. Access to instant medical information will enhance our ability to be cost effective as well as

increase our efficiency in meeting the needs of our patients. We must never let any "short cut" compromise our ability to be the guardians of our patients' medical information.

It is a well known axiom that organizations are like a chain. They will be no stronger than their weakest link. We must continue to encourage our membership to participate at whatever level persons are comfortable. We continue to look for talent and perhaps need to develop a talent bank that we can draw on in time of special needs. We are looking for persons willing to invest some of their time and talent on behalf of the entire profession.

In 1989, Dr James Davis, in his inaugural address as president of AMA said, "All physicians have a moral obligation to give back to their respective communities which give so much support to us." And many of us are giving back in varied and unique ways. In fact, we may well have the "best kept secret in the world" when we reflect on all of the projects of community service that physicians are leading across the state, including the outstanding work done by our KMA Alliance. Physicians and their families are making a significant and positive impact on the quality of life in the communities in which we live and practice. We must rid ourselves of timidity and share our story in the media and in the marketplace.

As physicians, we will always have our critics, but we would be



C. Kenneth Peters, MD

"Physicians and their families are making a significant and positive impact on the quality of life in the communities in which we live and practice. We must rid ourselves of timidity and share our story in the media and in the marketplace."

well advised to follow the lead of a well-known coach who said, "When in the field of competition, go to your strengths." We have many strengths that can move us forward into the twenty-first century, if we will pool our talents, our resources, and our resolve.

C. Kenneth Peters, MD
KMA President-Elect



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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

1997-98 Kentucky General Assembly

The Kentucky General Assembly completed its reorganization session in early January. Most action took place in the Senate where veteran Senate President John "Eck" Rose (D), Clark, was ousted by Larry Saunders (D), Jefferson. While "15 loyal Democrats" have refused to serve as committee chairs the make-up as announced by leadership of some committees creates concerns for medicine. Senator Benny Ray Bailey (D), Knott, has been elevated to chair of the Senate Appropriation and Revenue Committee, one of the most powerful positions in the legislature. Liberal and major proponent of non-physician practitioners, Walter Blevins (D), Morgan, has been elected President Pro Tem of the Senate and Ernesto Scorsone (D), Fayette, prime sponsor of HB 250, is Chair of the Banking and Insurance Committee. Even though Senate conservative Republicans gained equal representation on several committees favorable to social issue proponents, nevertheless medicine's job may be far more complicated. While Democrats appointed by the coalition of Republican and dissident Democrats have rejected committee appointments, it is important to note that had they accepted the appointments no great favor would have been accorded to medicine. In addition, Senate rule changes may force far more confrontational votes on controversial issues normally bottled up in committee. Based on KMA's experience, this rule change is not favorable to medicine.

On the House side, leadership races were rather benign. Speaker Jody Richards (D), Warren; Majority Floor leader, Greg Stumbo (D), Floyd; and Speaker Pro Tem Larry Clark (D), Jefferson, were all re-elected. The House Health and Welfare Committee is still chaired by Tom Burch (D), Jefferson, but the committee

appears to be fairly well divided among conservatives and liberals.

KMA Leadership Meets With Governor Patton

On January 14 KMA leadership met with Governor Paul Patton, Lt Governor Stephen Henry, MD, and Secretary of Health Services John Morse to discuss the Medicaid Partnership program. At the December meeting of the KMA Board of Trustees the Board adopted a position that while pilot programs are being developed in Regions 5 and 3 (Louisville and Lexington) implementation of partnership programs in the remainder of the state should be held in abeyance until the pilot projects clearly demonstrate value.

KMA leadership expressed its great concern with the impact of such programs on rural areas, especially Eastern Kentucky which has the largest number of beneficiaries. Leadership pointed to the lack of experience with managed care in rural areas and their inability to fund start-up costs, access to consultants, etc. One recent estimate of the start-up costs of a single partnership exceeded \$7 million. President William Mitchell, in noting problems incurred with "health care reform" under HB 250, urged caution in moving all of Medicaid patients and providers into a managed care entity in a single action.

The KMA urged Governor Patton to

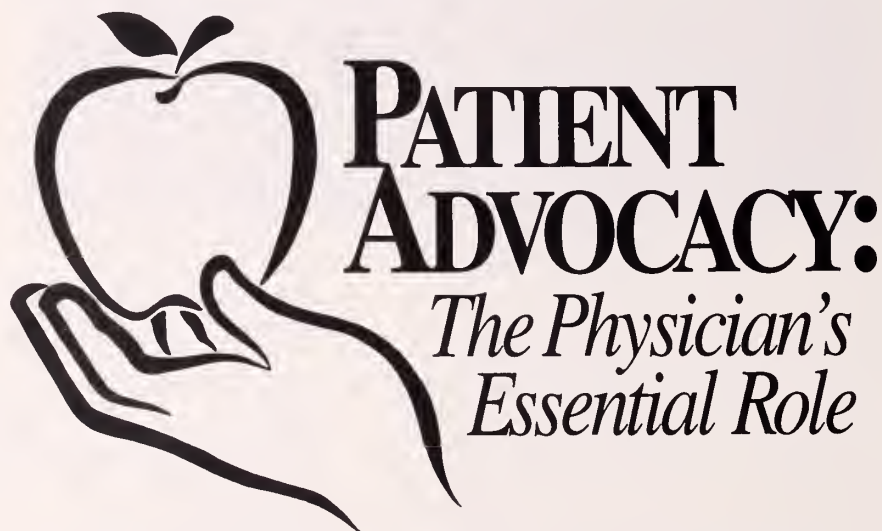
KMA

expand the nationally recognized KenPac program and enhance utilization management efforts that might improve KenPac to a level that privatization becomes unnecessary. The administration responded that future funding levels for Medicaid would not be increased other than possible inflationary increments. The Governor's comments meld with recent presentations at the AMA State Legislative meeting that Medicaid funding is a target of

Congress and states are expected to hold the line on Medicaid spending. Secretary Morse stated that under federal requirements Kentucky had to move forward with a capitated program in Medicaid and if providers could incorporate prescribed savings through a KenPac model, it might be acceptable.

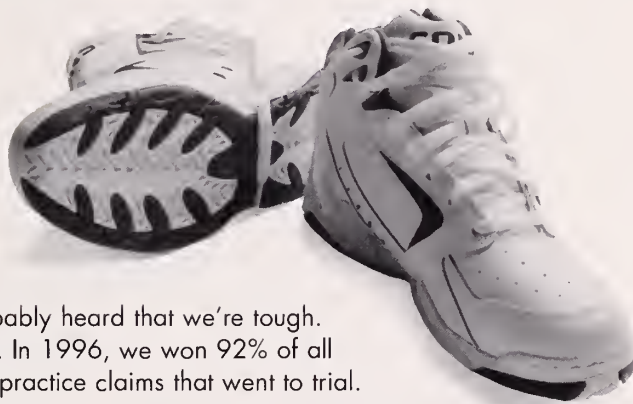
Finally, the Governor expressed great concern with the proliferation and prescribing of "legal drugs,"

particularly in Eastern Kentucky. He requested KMA's help and in the strongest terms stated that he fully intended to stop the illegal and inappropriate prescribing of narcotics. Governor Patton vowed to address the problem and indicated special legislation may be necessary. KMA leadership pledged their support to the Governor and scheduled a meeting with the Secretary of CHR to discuss this matter further.



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Acute Accidental Lithium Poisoning in a Child

Michael W. Simon, MD, PhD, FAAP

Poisonings are the fourth most common cause of death for children. Ingestion typically involves an accessible household product, especially medicine. Lithium may be accessible to children when it is used by family members or sitters. Lithium poisoning constitutes a serious medical condition with a 25% mortality rate. This article reports the accidental lithium poisoning of a child, its harmful effects and treatment.

Poisonings occur all too often and are the fourth most common cause of death during childhood.^{1,2} Estimates are that between 5 and 10 million childhood poisonings occur each year in the US.³ Approximately 90% of these incidents occur at home.⁴ Most poisonings are due to accidental ingestion.

The peak incidence for poisoning is between 1½ and 3 years of age, and again in adolescence.⁵ Adolescents may ingest drugs for experimentation from peer pressure, manipulation, or a suicidal attempt.¹ Approximately 80% of all poisonings occur in children less than 5 years of age.^{1,5} Poisoning in preschoolers is usually the result of curiosity for commonly accessible household products like cosmetics, cleaning products, plants, personal care products, and medicine.⁶

This article reports the accidental home ingestion of lithium by a child and reviews fundamentals of its harmful effects and treatment.

Case Report

The 2-year-old child was in his usual state of good health until the day of admission when he was noted to have episodes of unresponsiveness interrupted by periods of wild behavior and ataxia. He had choreiform writhing movements. The child produced mumbling sounds, but no understandable speech. He would not maintain eye contact, but had a blank stare. The family remarked that he had tremendous thirst and massive urine output. The urine flooded his diaper and he had to

be changed hourly. He had three diarrhea stools since awakening that morning. They were concerned that approximately 12 hours before he developed the bizarre symptoms, the babysitter had spilled her bottle of lithium (300 mg/capsule) and that all the capsules may not have been retrieved.

The physical examination and vital signs were normal. He was observed in the office to chaotically run wild into the walls and office furniture, seem stunned and unhurt, then sit quietly. The child was admitted to the hospital for evaluation and observation. Intravenous fluids were started consisting of D5½ normal saline plus 20 meq potassium chloride/1 at a maintenance fluid rate. A serum lithium level was 1.8 meq/1. No other drugs were detected. The electrolytes and electrocardiogram were normal. The urine had a specific gravity of 1.000 and negative on the urinalysis Chemstrip. The child continued to alternately doze and be awake and agitated. He was transferred to a critical care unit for close observation of lithium intoxication.

A repeat serum lithium level collected approximately 2 hours after the first level was 1.8 meq/1. He continued intravenous fluids but received no additional therapy. Over the next 12 hours the child returned to normal. He recognized his parents, spoke in sentences and played with toys. There was no unusual behavior or neurologic activity. The diarrhea stopped and he had four diapers wet with urine. A serum lithium level 12 hours after the second level was 1.5 meq/1. He was discharged to home and continues to do well at routine follow up. No neurologic or renal sequelae have been observed.

Discussion

Lithium was first recommended as a treatment for depression by Lang in 1897.⁷ However it has only been since the late 1940s that it has been used for a variety of different psychiatric disor-

Lithium Poisoning in a Child

ders.^{8,9,10} Lithium was used as a salt substitute prior to 1950 in a variety of commercial products, most notably the soft drink beverage "7-Up."^{9,11}

Lithium poisoning is less frequent now, but may still occur in homes where it is used for medicinal purposes by family or sitters. Acute overdose has a 25% mortality rate and constitutes a serious medical problem.⁷ Lithium is completely and rapidly absorbed by the gastrointestinal tract and distributed in the total body volume of water. However it has a slow uptake as well as release across the blood brain barrier. This delays its initial central nervous system effect but prolongs the toxic effects on the brain.

Lithium is primarily eliminated by the kidneys with a small contribution from the gastrointestinal tract.^{7,11} For the renal load of lithium, 80% is reabsorbed at the proximal tubule and 20% excreted in the urine.^{10,12} The normal half life of lithium is 24 hours. However, the renal clearance is more rapid in younger individuals.¹³ This is why younger individuals tend to better tolerate higher levels of lithium. Because lithium has a prolonged elimination time, symptoms of lithium poisoning may evolve and worsen.

The symptoms of lithium poisoning are the result of the serum lithium concentration plus the duration of the toxic lithium level.⁷ Certain clinical manifestations may be seen at different serum lithium levels (Table 1). Mild toxicity is seen with a serum concentration of 1.5–2.5 meq/l. Serious toxicity occurs at 2.5–3.5 meq/l. Life threatening toxicity occurs at a level exceeding 3.5 meq/l.¹¹ The child in this report had a lithium level of 1.8 meq/l. Two initial concerns were that it was unknown when the peak lithium level would be reached and if he ingested additional lithium that would in time produce a life threatening level.

Gastroenteritis and diuresis are early signs of acute lithium poisoning. The child in this report

had these manifestations. Lithium may also produce natriuresis with water loss. Additionally, nephrogenic diabetes insipidus with polydipsia that is unresponsive to ADH may develop.^{14,15} Any underlying renal disorder may predispose to lithium toxicity.⁷ Dehydration, vomiting, diarrhea, restriction of sodium intake and zealous exercise may worsen lithium toxicity through promoting sodium and water imbalance. Lithium poisoning may cause acute tubular necrosis.¹¹

Lithium may produce central nervous system and cardiac changes. The child reported here had choreiform movements, hyperirritability, confusion, anxiety, delirium, spasticity and mental changes, all seen in lithium toxicity. Parkinsonism, cogwheel rigidity and stupor may occur. Myocarditis, arrhythmias, flattening or inversion of the T waves and prolonged QRS complex may be seen with lithium poisoning. When poisoning is severe, hypotension and circulatory collapse may occur.⁷

There is no antidote for lithium poisoning. Treatment is directed toward symptomatic measures, fluid and electrolyte balance with dialysis used for severe toxicity. The fluid and electrolyte balance needs to be restored and maintained. Sodium and water should not be restricted. Fever should be controlled because it increases water loss.

Forced diuresis should be avoided unless the glomerular filtration rate is below normal.^{7,14} A fluid bolus may be required if hypovolemia is present. Patients with nephrogenic diabetes insipidus should receive half normal saline. Normal saline for these children may produce hypertonicity that could increase morbidity and mortality. Abrupt electrolyte changes should be avoided.

Lithium is the most dialyzable toxin known. This is a result of its small molecular weight and negligible protein binding. Hemodialysis is the method of choice for treating severe lithium poisoning.^{7,16,17} Peritoneal dialysis may be used if hemodialysis is not available.

Dialysis reduces the half life significantly by rapidly reducing the serum lithium concentration. Redistribution of lithium in different compartments including continued gastrointestinal absorption may produce a rebound in the plasma level. If the level is more than 1 meq/l at 6–8 hours after dialysis, repeat hemodialysis may be necessary. Even when the serum lithium level is reduced by dialysis, recovery from the toxic effects may be slow. This may be the result of the intracellular lithium producing prolonged meta-

Table 1. Lithium Toxic Effects

Low Level	High Level	Very High Level
Polyuria	Sleepiness	Hyperreflexia
Polydipsia	Vomiting	Muscle Fasciculations
Fine Hand Tremor	Diarrhea	Nystagmus
Dizziness	Coarse Hand Tremors	Oliguria
Jerky Movements	Vertigo	Anuria
Diarrhea	Dysarthria	Convulsions
		Coma

bolic and neuroendocrine effects as well as its slow release from the central nervous system.

After lithium poisoning, patients need close monitoring. Approximately 10% will have renal and neurologic deficits. The fluid balance may be disturbed up to weeks from a persistent renal sodium and water loss. For some individuals the central nervous system manifestations never completely resolve.¹⁸ Irreversible brain damage to the cerebellum and basal ganglia may occur after acute poisoning.¹³ Neurology and nephrology follow up may be advisable.

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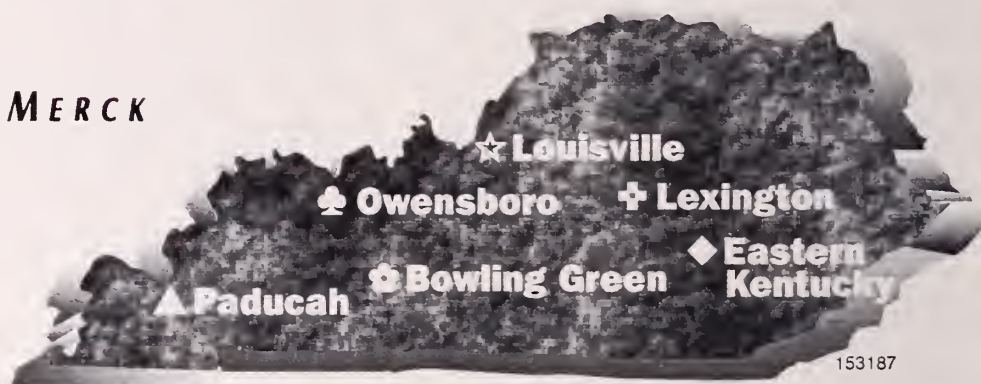


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Spontaneous Rupture of Abdominal Aortic Aneurysms in Patients With Non-Related Blunt Traumatic Injuries

Eddy H. Carrillo, MD; Enrique Ginzburg, MD;
Nicholas Namias, MD; Larry Martin, MD

From the Department of Surgery, University of Louisville, Louisville, KY (Dr Carrillo), and the Department of Surgery, University of Miami School of Medicine, Jackson Memorial Medical Center, Miami, FL (Drs Ginzburg, Namias, and Martin).

As the population ages, abdominal aneurysms are expected to increase in frequency, as well as in the number of elderly patients involved in automobile trauma. Therefore, the number of incidental abdominal aortic aneurysms found in elderly trauma patients should be expected to rise. The purpose of this paper is to report two cases of ruptured abdominal aortic aneurysms found after nonassociated blunt trauma. We review the literature and discuss possible etiologic factors and management associated with this problem.

The vast majority of abdominal aortic aneurysms (AAA) are atherosclerotic in origin, likely related to turbulent flow at the bifurcation of the abdominal aorta.¹ The natural history of untreated AAA is one of progression to rupture; for this reason, AAA >5 cm in diameter should be operated on soon after the diagnosis is made.² The majority of AAA are asymptomatic until rupture, characterized by shock and pain in the back and flanks due to peritoneal and retroperitoneal hemorrhage. The results of elective AAA repair are excellent, with an expected mortality rate of less than 5%,³ in contrast to emergency operation for ruptured AAA, where the mortality rate remains 60% to 80%.⁴ This is the rationale for routine repair of AAA >5 cm in diameter performed soon after diagnosis.⁵ Spontaneous rupture after non-related abdominal surgery has been previously recorded,^{6,7} but to our knowledge, this is the first report of spontaneous rupture after blunt traumatic injuries. The following cases of blunt trauma illustrate the probable need for early surgical intervention in these patients.

Patients

Patient 1. A 71-year-old man was taken to the nearest emergency facility after being involved in a head-on motor vehicle accident. After initial evaluation, he was transferred to our facility, a Level One trauma center. His past medical history was remarkable only for chronic bronchitis. Upon arrival he complained of chest pain and dyspnea. Physical examination revealed that he was in respiratory distress. He was afebrile and normotensive, his heart rate was 128 beats/min and respiration rate was 28/min. His arterial oxygen saturation measured by pulse oximetry was 86%. There were seat belt marks on his anterior chest. Subcutaneous emphysema and decreased breath sounds were noted on his right side and paradoxical movement of the right chest suggested flail chest. His upper abdomen was soft with no peritoneal signs and there were no palpable masses. The results of the physical examination were otherwise negative. He was tracheally intubated and a right chest tube was placed. A chest film revealed fractures of the fourth through ninth right ribs. Computerized tomography (CT) of the chest and abdomen showed a small pleural effusion and diffuse subcutaneous emphysema of the right chest. The abdominal CT scan revealed a calcified AAA, measuring 5.5 cm in diameter (Fig). After the initial diagnostic workup was completed, the patient was admitted to the trauma intensive care unit for respiratory support. A pleural catheter was placed for administering analgesia. His respiration slowly improved with mechanical ventilatory support, bronchodilators and steroids, and he was extubated 3 weeks after his admission. A vascular consultation was obtained,

and the consensus was that this patient was not then a good candidate for AAA repair. All support tubes were removed and the patient was enrolled in a program of respiratory and physical therapy.

One week after being transferred to a rehabilitation facility, the patient was found unconscious and without vital signs. Efforts at resuscitation were futile. At post mortem examination it was found that a 10×15 cm AAA had ruptured into the left retroperitoneal space.

Patient 2. A 70-year-old man was seen in the surgical emergency room following a single car motor vehicle accident in which he was the restrained driver. He had hit a utility pole. En route to the hospital he was awake and alert. His past medical history was unremarkable except for "mild" arterial hypertension controlled with a calcium channel blocker. Physical examination revealed that he was alert and in no acute distress. He was afebrile and normotensive with a heart rate of 96 beats/min and a respiration rate of 14/min. He had sustained a laceration of his forehead and scalp, approximately 6 cm long, and he was tender over the right rib cage. The results of the rest of the physical examination were unremarkable. A chest x-ray showed fractures of the anterolateral right sixth and seventh ribs, with no other acute findings. An abdominal ultrasound did not show any evidence of acute traumatic injuries; however, it showed an infrarenal AAA measuring 5 cm at its greatest diameter. The patient was admitted for observation and physical therapy and to control the pain associated with his rib fractures and pulmonary contusion. Approximately 3 days after admission, the patient suddenly became hypotensive and diaphoretic, and he died despite attempts at airway control and resuscitation. Post mortem examination revealed the rupture of an 8×10 cm infrarenal AAA into the retroperitoneum.

Discussion

One of the earliest associations between operative trauma and coincidental postoperative AAA rupture was reported by Trueblood et al.⁶ They reported four cases of aneurysms that ruptured following resection of abdominal malignancies, representing a 24% mortality rate for elective surgery in patients with known AAA.

In 1980, Swanson et al⁷ reported on ten patients who suffered ruptured AAA within 36 days of prior laparotomy and hypothesized that the trauma of laparotomy disturbed the dynamic

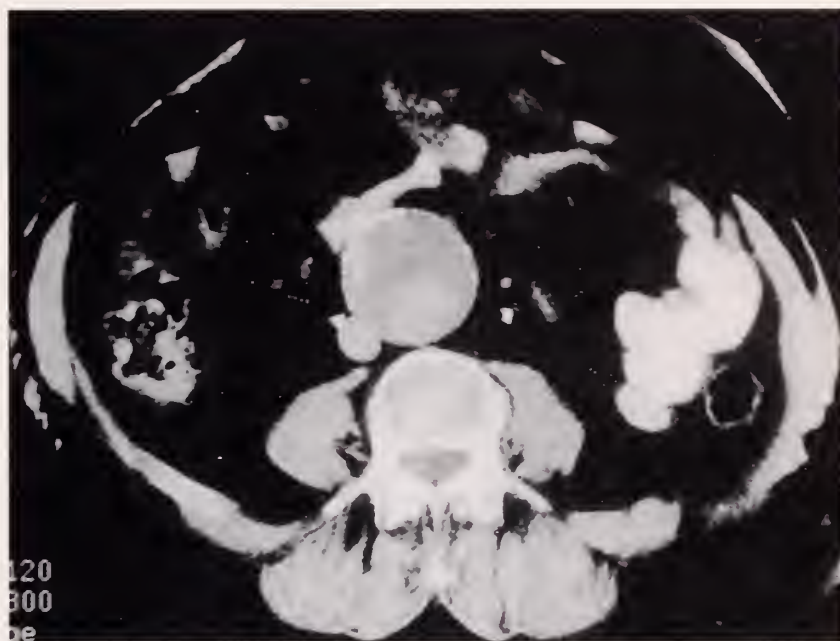


Fig — Computerized tomography of an infrarenal abdominal aortic aneurysm, measuring 5.5 cm at its greatest diameter.

equilibrium between collagen synthesis and degradation in the wall of the aneurysm, and they suggested the need for aggressive vascular intervention prior to elective surgery. Factors often seen with multiple trauma patients — nutritional depletion, vitamin C deficiency, increased plasma corticosteroids, low PaO_2 , and shock and sepsis — interfere with collagen synthesis.⁸ Postmortem studies of aortic aneurysmal walls have shown that the outer layer of the aorta is replaced by fibrotic scar-like collagen, which is nonuniform in its distribution and may result in potential rupture.⁹

Early animal studies demonstrated that collagen lysis exceeds collagen synthesis after injury and periods of starvation, based on increased collagenolytic activities removed from the site of injury.¹⁰ More recent studies have also supported the view that AAA have increased collagenase activity in ruptured aneurysms.¹¹ However, a recent study by Cohen et al¹² suggests that collagenase activity is a localized reaction at the site of the initial injury, and that operative trauma without direct aortic injury has no effect on aortic collagenase activity. Supporting this view is another recent study in poststenotic dilated segments of primate aortas where collagenase was difficult to isolate but was localized to the vasa vasorum,

Rupture of Abdominal Aneurysms in Blunt Trauma

correlating to increased rupture rates in those aneurysms that have had prior surgical manipulation.¹³

Controversy about the role of collagenase can be partially explained by methods of staining and identifying the collagenase in AAA, but work by Powell,¹⁴ in England, has also demonstrated that elastin content and elastase activity are decreased and increased respectively in AAA.

The limited reports on this topic all emphasized that size (>5 cm) resulted in the greatest potential for coincidental rupture and in higher mortality rates than simple rupture of AAA.

Conclusion

In view of our findings, we recommend early repair of large (>5 cm) AAA after trauma for patients with AAA found on admission, once the traumatic injuries have been addressed and potential complications resolved. Patients with aneurysms <5 cm should undergo sequentially duplex scanning to assure that there is no rapid expansion of their AAA while they are hospitalized. In the future, the use of percutaneous aortic prostheses will likely be the treatment of choice in these patients. Conclusive evidence would be supported by a well-controlled study.

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The Surgical Implications of Primary Hypercoagulable States

Thomas M. Bergamini, MD; J. David Richardson, MD

Primary hypercoagulable states are hereditary disorders that result in arterial and venous thromboses. The purpose of this report is to present three patients with hypercoagulable states, and offer current guidelines for diagnosis and treatment. Primary hypercoagulable disorders such as antithrombin III, protein C and protein S deficiencies, fibrinolytic disorders such as decreased plasminogen levels and plasminogen activator deficiency, and antiphospholipid syndromes such as anticardiolipin antibody and lupus anticoagulants will be reviewed. We will emphasize clinical characteristics that should prompt evaluation for hypercoagulation, appropriate laboratory tests for hypercoagulable disorders, and treatment. Other secondary and recently investigated hypercoagulable disorders, including heparin-associated thrombocytopenia, homocystinemia, lipoprotein (a), plasminogen activator inhibitor, and factor V Leiden, will also be reviewed.

Hereditary disorders of clotting that result in the inability of the blood to clot normally have long been recognized and include problems such as hemophilia and von Willebrand's disease. However, in the last 2 decades there is increased awareness of hypercoagulable syndromes associated with arterial and venous thromboses.¹⁻⁴ This report describes several illustrative patients with hypercoagulable syndromes, outlines some of the most common causes of these syndromes, and offers a plan for the evaluation and treatment of these patients.

Case Reports

Patient 1. A 54-year-old man with no history of vascular disease developed swelling in one leg after driving from Florida to Kentucky. No risk factors for venous thrombosis were identified but his family history was positive in that his father

and paternal uncle died of what was described "blood clots to the lungs." Duplex scanning of his left leg disclosed a large femoral vein thrombus. After he completed a course of heparin therapy, the patient was maintained on oral warfarin. Determination of antithrombin III (ATIII) levels disclosed a value of 44% of normal levels. The patient has been maintained on oral anticoagulation for 6 years without further sequelae.

Patient 2. A 62-year-old woman with severe chronic limb ischemia was found to have a thrombosed aorta immediately below the renal arteries shown on angiography. Her past medical history was significant for a symptomatic thrombosis of the left carotid artery, following a carotid endarterectomy 2 years earlier. She had never smoked and did not have diabetes mellitus; her cholesterol and triglycerides were mildly elevated.

An aortobifemoral bypass graft was planned but after completion of the proximal anastomosis, blood flow could not be reestablished in the aorta and there was a clot present at the renal artery orifices. The passage of a large embolectomy catheter proximally in the aorta did not reestablish blood flow and a large amount of fresh intra-aortic thrombus was noted, despite 10,000 units of heparin administered initially and a repeat dose of 10,000 units. An intraoperative consultation with a hematologist was obtained; ATIII levels were obtained emergently but were not detectable.

The patient was given fresh frozen plasma and ATIII concentrate to restore adequate protein levels. High-dose heparin was given along with low molecular weight Dextran and rectal aspirin. Technical factors appeared to be suboptimal for salvaging the aortic reconstruction and an axillofemoral bypass was performed. The patient was maintained on ATIII concentrate and anticoagulants postoperatively and the graft remained patent. Subsequently, her ATIII levels were 20%

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Surgical Implications of Primary Hypercoagulable States

and 24% of predicted values. (The patient's two children had ATIII levels measured at 48% and 62%). After 2 years, the patient's graft occluded and she developed claudication, but her lower limbs remained viable. One year later, she developed vague abdominal pain that was associated with ascites and jaundice. A duplex scan of the abdomen showed portal vein thrombosis. She was treated with ATIII concentrate and heparin but she died of fulminant hepatic failure within a few days. A postmortem examination showed that the patient's portal and hepatic veins were totally thrombosed with hepatic necrosis.

Patient 3. A teenager developed deep venous thrombosis in 1976. Subsequently, he had several episodes of mesenteric venous thrombosis and eventually had multiple bowel resections that caused short bowel syndrome. After protein C levels were shown to be markedly decreased, the patient was maintained on a combination of oral and parenteral nutrition. He received total parenteral nutrition (TPN) for over a decade to maintain his body weight and hydration and during this period, multiple procedures were required to provide venous access. Eventually, direct cannulation of the inferior vena cava was required.

Despite many innovative attempts to discontinue parenteral nutrition by using treatments such as growth hormone stimulation to promote bowel growth, the patient continued to require TPN. Unfortunately, catheter-associated sepsis eventually led to multiple thrombotic events, and

he died 20 years after his initial episode of deep venous thrombosis.

Hypercoagulable States

Hypercoagulable states are being recognized with increasing frequency as a cause of both venous and arterial thrombosis.^{1,4} A recent study⁴ of 49 patients with unexplained venous or arterial thrombosis disclosed 27 patients with documented hypercoagulable states, including those with deficiencies of the body's natural anticoagulants such as ATIII, protein C or protein S or heparin cofactor II. Patients with this type of disorder are considered to have primary hypercoagulability as opposed to secondary coagulability, which may occur as a result of other conditions or disease states (Table 1).

Most of the causes of primary hypercoagulability are hereditary disorders involving proteins of the coagulation or fibrinolytic system.⁵ The typical pattern of inheritance is by an autosomal dominant mechanism; generally the homozygous state is incompatible with life, while the heterozygous situation has diminished levels of natural anticoagulant that may or may not be problematic.⁶ Persons with a decreased level of natural anticoagulants usually become symptomatic in the second or third decade of life, or at a time of stress that would predispose normal clotting, including trauma, operations, pregnancy, and prolonged immobilization.

The three naturally occurring or physiologic anticoagulant mechanisms are (1) ATIII, (2) proteins C and S, and (3) the fibrinolytic system. Deficiencies in ATIII are the most common disorders documented at this time.^{6,7}

Antithrombin III (ATIII) Deficiency

ATIII deficiency is relatively common, occurring in an estimated 1 in 2,000 people to 1 in 5,000 people.^{5,6} In the heterogeneous state, ATIII levels are usually 25% to 60% of normal measurements in the population at large. Many laboratories can perform coagulation measurement tests of ATIII levels. Occasionally, a patient who may have a normal ATIII level as measured by immunoassay will, in fact, have a decrease in the functional level of ATIII.

The clinical spectrum of problems encountered with ATIII deficiency includes both venous and arterial thrombosis with predominant venous clotting. ATIII deficiency usually causes deep ve-

Table 1. Causes of Hypercoagulability

Primary	Secondary
Antithrombin III deficiency	Malignancy (particularly mucinous gastrointestinal cancer)
Protein C deficiency	Pregnancy
Protein S deficiency	Oral contraceptives
Fibrinolytic disorders including	Myeloproliferative disorder
Decreased plasminogen levels	Hyperlipidemia
Plasminogen activator deficiency	Diabetes Mellitus
Dysfibrinogenemia	Heparin induced thrombocytopenia (cytopenia)
Lupus anticoagulant	Non-endothelial surfaces
	Vasculitis
	Homocystinuria
	Increased viscosity (eg, leukemia, polycythemia, sickle cell disease)
	Thrombotic thrombocytopenic purpura

nous thrombosis or pulmonary embolism. A meta-analysis review³ of recent literature suggests that half of the patients with ATIII deficiency had venous thrombosis and 2% had arterial thrombosis.⁷ A review of a number of patients with this disorder followed prospectively suggested that about 20% developed venous thrombosis.⁷ Many patients are asymptomatic throughout their life and others become symptomatic only when they have physiologic stress.

The treatment of ATIII deficiency is controversial if it is detected on a screening study in an asymptomatic patient. This study is not usually performed routinely, but it is generally done when a member of the family is affected or when other family members are screened. The current recommendation usually made for asymptomatic patients is for anticoagulation therapy to be given at the time of high risk events for thrombosis. Pregnancy represents a special problem because warfarin cannot be used owing to its potentially teratogenic effects. In this situation, treatment with low molecular weight heparin, administered daily, appears to be the best therapy. Once symptoms occur, the use of long-term oral anticoagulants is usually recommended.

Heparin requires adequate levels of ATIII to activate its anticoagulant properties.⁷ Therefore, heparin may not be effective in patients with very low levels of ATIII, as was shown in Patient 2. Levels of ATIII can be restored by the use of fresh frozen plasma and ATIII concentrates, but the latter is expensive, potentially infectious and should be used only in specific circumstances.

Proteins C and S Deficiency

Proteins C and S are vitamin K-dependent proteins that when activated act as anticoagulants by deactivating Factors V and VIII. Thus, these proteins act to regulate fluidity of the blood and to prevent in situ thrombosis.⁵ The genetic inheritance patterns of these disorders are similar to that of ATIII, although they occur less frequently. Secondary deficiencies in these proteins have been reported in patients with acute inflammation and human immune virus infections and may account for the increased incidence of thrombosis reported in both of these groups.

Proteins C and S can be measured directly to permit an accurate diagnosis of their deficiency. Initial treatment should consist of heparin and warfarin followed by long-term maintenance with oral anticoagulants.

Fibrinolytic Disorders

Various disorders of fibrinolysis have been described, but generally they can be divided into abnormalities of plasminogen itself or of a defect in the release of plasminogen activator from the wall of blood vessels. Dysfibrinogenemias have been reported; most result in excessive bleeding but a few cases of hypercoagulable patients have been reported.

Lupus Anticoagulant

Lupus anticoagulant is an acquired immunoglobulin that was originally described in patients with systemic lupus erythematosus (SLE).⁸ Lupus anticoagulant may occur with SLE or it may be present without associated illnesses or conditions. Patients with lupus anticoagulant are prone to thrombosis, especially if they have SLE. These problems usually come to surgeons' attention because this anticoagulant inhibits the activity of phospholipid in vitro clotting tests in preoperative patients. This results in a prolonged partial thromboplastin time, and prothrombin time which may be detected on routine preoperative screening. If this is noted in the preoperative patient, it is thrombosis rather than abnormal bleeding that represents the greatest risk.

Conditions Prompting Evaluation

The tests to diagnose or exclude primary hypercoagulability require a sophisticated laboratory and they are expensive. Routine screening should not necessarily be performed even if an episode of vascular thrombosis has occurred, but there are certain clinical conditions that should alert the physician to the possibility of a primary hypercoagulable situation (Table 2). These would in-

Table 2. Factors Prompting Evaluation for Hypercoagulation*

- Recurrent spontaneous thrombosis (without apparent or predisposing cause)
- Thrombosis with minimal trauma or stress
- Family history of thrombosis
- Vascular occlusion at an early age
- Thrombosis in vessels in unusual sites
- Failure to respond to conventional anticoagulation therapy

*Some investigators recommend that all patients with deep venous thrombosis or pulmonary embolism be evaluated.

Surgical Implications of Primary Hypercoagulable States

clude a family history of unusual thromboses in multiple family members. Recurrent vascular disease without apparent cause or predisposing factors should be viewed with a high index of suspicion. Patients who have thrombosis at an early age or at an unusual site should be evaluated for primary hypercoagulable states. We have seen mesenteric venous occlusion in several young patients (including Patient 3) who have subsequently been diagnosed with primary hypercoagulable disorders. Patients who are not responsive to standard anticoagulants should be considered as having these disorders as well. Heparin resistance in patients with ATIII disorders is a particularly potential problem for vascular surgeons, as illustrated in Patient 2. Some hematologists advocate evaluation for every patient with a history of venous clotting, but we have not pursued this course if obvious risk factors are present.

Secondary and Recently Investigated Hypercoagulable Disorders

Heparin-associated thrombocytopenia (HAT) is seen in approximately 4% to 10% of patients who receive heparin therapy.⁹ The incidence of HAT is significantly higher following the use of bovine heparin as compared to porcine heparin. This syndrome usually occurs 1 to 2 weeks following heparin therapy, and it has been associated with full dose heparin therapy as well as with the low doses of heparin, used in heparin flushes and subcutaneous heparin therapy. No clinical signs or symptoms are accurate in predicting which patients will develop HAT, nor is there sex predilection or age factor in those who develop HAT on heparin therapy. Heparin-associated thrombocytopenia should be considered in patients who develop resistance to heparin or who develop thrombocytopenia; HAT is frequently associated with arterial thrombotic complications and, less frequently, with venous thrombosis. Diagnosis of HAT is confirmed with studies of platelet aggregation and heparin-associated antibodies. When the diagnosis is confirmed, treatment should include removal of all sources of heparin, including heparin-bonded catheters and heparin flushes. Intravenous low molecular weight Dextran-40 or oral aspirin therapy should be instituted.

Other recently investigated disorders associated with thrombosis and onset of atherosclerosis include elevated homocysteine, lipoprotein (a), and plasminogen activator inhibitor (PAI-1). Elevation of these factors has been associated with

earlier onset of atherosclerotic vascular disease and thrombotic complications. This is similar to the early onset of atherosclerotic disease seen in patients with anticardiolipin antibodies. Patients with homocystinuria^{10,12} have a hereditary autosomal recessive disorder that is secondary to deficiency in cystathione B-synthase. It is characterized by ocular and skeletal malformations, mental retardation, and premature atherosclerosis and thrombosis. Heterozygotes have also been shown to have elevated blood homocysteine levels and are at increased risk for thrombosis. Possible mechanisms of action for the increased thrombosis include endothelial damage, activation of factor V, or a decrease of protein C activation by the endothelial cell. Patients less than 55 years of age with coronary and peripheral vascular disease have an incidence of homocystinemia ranging from 28% to 47%, in recent reports.^{10,12} The recognition of elevated homocysteine in young patients may be important, because treatment could be as simple as administration of agents such as pyridoxine, folate, or Vitamin B-12. High levels of lipoprotein (a)^{13,14} have also been shown to be associated with early atherosclerosis and thrombotic complications. Lipoprotein (a) closely resembles the structure of plasminogen and may attenuate fibrin-mediated enhancement of tissue plasminogen activator effect on plasminogen. Lipoprotein (a) does increase the levels of PAI-1. Elevated levels of PAI-1 have also been associated with early onset of atherosclerosis and thrombosis.

Recent reports have associated venous thrombosis with resistance to activated protein C.^{15,16} This was associated with a point of mutation or substitution of a single base nucleotide 1691 of the gene coding for coagulation factor V, which substitutes adenine for guanine. This previously unrecognized form of coagulation factor V has normal procoagulant activity but is resistant to the proteolytic inactivation of factor V by activated

Table 3. Hypercoagulable Disorder

- Laboratory evaluation
- Hemoglobin/Hematocrit, platelet count
- Prothrombin time, partial thromboplastin time
- Antithrombin III levels
- Protein C and Protein S levels
- Serum plasminogen/fibrinogen levels
- Anticardiolipin antibody/lupus anticoagulant levels
- Heparin-associated thrombocytopenia/platelet aggregation and heparin antibody studies

protein C. This mutation in gene coding does predispose to venous thrombosis. It has not been associated with arterial thrombosis, myocardial infarction or stroke. A mutation at factor V can be detected with a functional assay to determine the presence or resistance to activated protein C or with molecular genetic analysis. It is currently not known whether patients with the mutation should be treated with aggressive prophylaxis or anticoagulation.

Laboratory Evaluation of Primary Hypercoagulability

It is difficult to determine which patients should have a laboratory evaluation. Most patients with hypercoagulable disorders do not have any specific signs or symptoms to suggest their disease process. Only patients with lupus anticoagulant who have an elevated partial thromboplastin time (PTT) and patients with HAT with a drop in platelet count, will have results in their routine laboratory tests that suggest a hypercoagulable disorder. Generally, one must rely upon the conditions described previously, abnormal thrombotic complications in young patients, patients with a family history of thrombosis, recurrent thrombotic events, spontaneous thrombosis, unusual ascites, and unexplained arterial thrombosis (Table 2), as reasons for an evaluation. Even with this policy the yield will be very small. Several studies^{17,26} have shown that the incidence of a hypercoagulable disorder in patients with venous thromboembolism ranges between 1% to 12% for ATIII deficiency, 1% to 13% for protein C deficiency, 1% to 18% for protein S deficiency, 0.6% to 1.8% for abnormal fibrinogen, 1% to 3.5% for abnormal plasminogen, and 1.9% to 3.7% for antiphospholipid antibody syndrome, including those with abnormal lupus anticoagulant with an elevated PTT. The yield is similarly low in vascular surgery patients,^{27,31} with the incidence of ATIII deficiency occurring in 1.3% to 16.4%, protein C deficiency in 1.7% to 20%, protein S deficiency in 1% to 15.8%, abnormal plasminogen in 10%, and antiphospholipid antibody syndrome in 3.5%.

When a hypercoagulable disorder is suggested, the laboratory tests that can be ordered are shown in Table 3. Reductions in ATIII are measured by both immunologic and functional assays.³² Most patients with a hypercoagulable disorder will have an abnormally low ATIII protein concentration; however, certain patients will have normal levels but decreased biologic func-

tion.^{33,34} It is important to remember that ATIII concentrations can be falsely lowered by the administration of heparin, oral contraceptives, nephrotic syndrome, liver disease, and malnutrition.³⁴ Standard methods for measuring protein C and protein S include radiolabeled electroimmunoassay of plasma samples. Falsely low levels can occur in patients with liver failure as well as in patients already on Coumadin therapy, which is a vitamin K-dependent protein. Serum plasminogen level tests are performed using immunoelectrophoresis, with molecular defects in the plasminogens noted by an abnormal band on the electrophoretic pattern.³⁵ In patients with unexplained thrombosis, it is important to keep in mind disseminated intravascular coagulation and other hereditary deficiencies in clotting factors such as factors V, VIII, and X deficiency.

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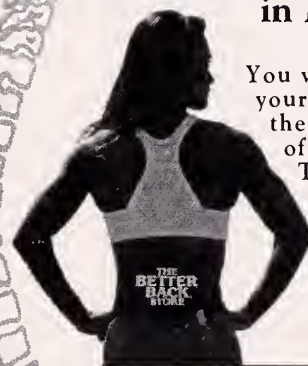


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Keep in Touch

Through the kindness of a friend, I recently had the opportunity to listen to a recording of a lecture on Sir Winston Churchill. The lecturer had as his primary goal an analysis of why we find Sir Winston such an accessible and beloved political figure. He began his dissertation with the premise that Churchill is beloved at least in part because he assumed his role on the world-wide stage at such a late age, and then continued to be a palpable presence until well into his eighties. He continued with the assertion that Churchill was such a "character" that the common man found in him much of himself, and that he had such foresight that every man could see in him the wisdom he wished to attain. He concluded with the argument that Churchill's wit was so thoroughly engaging that we could not help but be enamored of him.

While Churchill's life, long and full as it was, certainly draws a host of interpretations, I felt that the lecturer captured several key components of his life. It similarly seemed that he was articulating several key issues impacting our profession in this day and age. While medicine has an ancient and important history, the growth and development of our tools and skills has been explosive only relatively recently. Our emergence as

an "industry" has been even more recent. Churchill drew on all of his knowledge of British and world history to craft and execute the plan that helped thwart Hitler's Germany. He incorporated his extensive personal experience as a politician and orator to convey his vision to the people of Britain and the world. As a profession we must likewise tap our rich history to understand those core principles of our discipline and employ our personal experience to convey to our communities and our patients the honor inherent in what we do.

In the same way that Churchill seemed to touch the common man so personally, we must remember how personally and intimately we touch each of our patients. The more that they see us as accessible to them and understanding of them, the more that they will appreciate what it is we do for them and for all with whom we interact. As Churchill gained our admiration with his vision of what was to happen prior to World War II and prior to the Cold War, we must regain our patient's admiration for our ability to see past bothersome operational, logistical, and economic issues and remain focused on the primacy of our service to patients and our community. Churchill spent an

exceptional amount of time thinking and writing about the great issues of his age and was prepared to act when his moment presented itself. It is incumbent on us as physicians to do the same so that we are similarly prepared to act on, not react to, issues affecting us and our patients.

The lecturer omitted one dimension of Churchill which I believe endeared him to us as much as anything: his failures. He lived out his life in public and on a grand stage. When he failed, he rarely failed discreetly. We have the privilege as physicians to participate in the most intimate and personal moments of people's lives simply by virtue of the fact that we are physicians. When we fail, be it at the bedside or in the public policy forum, it is rarely unnoticed. Churchill turned his defeats into the tools of glorious victories by learning the lessons they taught, by defying those who sought to exile him, by resolutely rebuilding hope, and by demonstrating magnanimity towards those whom he had proven wrong. He never lost his sense of humor or the ability to laugh at himself. We would do well, for our own sake and for the sake of our patients, to do the same.

Daniel W. Varga, MD

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1997

FEBRUARY

21-26 — AAAAI/AAI/CIS Joint Meeting (American Academy of Allergy, Asthma and Immunology/American Association of Immunologists/Clinical Immunology Society), San Francisco. Contact: 1997 Joint Meeting Secretariat American Academy of Allergy, Asthma and Immunology, 611 E Wells St, Milwaukee, WI 53202; 414/272-6071; FAX 414/267-3349.

MAY

9-16 — 56th Annual American Occupational Health Conference, Orange County Convention Center, Orlando, FL. Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; phone 847/228-6850; fax 847-228-1856.

JUNE

23-August 29 — 18th Cape Cod Institute, a series of week-long postgraduate courses for mental health, health science and behavioral science professionals; Albert Einstein College of Medicine, Bronx, NY. Contact: Gilbert Levin, PhD, Albert Einstein College of Medicine, 1308 Belfer Bldg, Bronx, NY 10461; phone 718/430-2307; fax 718/430-8782; E-mail: glevin@aecom.yu.edu.

26-29 — Clinical Magnetic Resonance Society Annual Meeting, Walt Disney World SWAN, Disney World/EPCOT Center, Orlando, FL. Contact: 800/823-2677 or 513/221-0070; FAX 513/221-0825; e-mail: cmrs@one.net

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NOW COUNT YOUR MEN, HITLER! *Memoirs of an Infantryman*

Milton F. Miller, MD

Zorn Avenue Publications
with assistance from
The Sulgrave Press
2005 Longest Avenue
Louisville, KY 40204

This 112-page book catches your interest immediately. Titled from the gunner's battle cry and filled with numerous chapters of recollections, this chronology makes for informative and sympathetic reading. Those of us who have not faced war, but served in the military, understand the anxiety of entering a world full of commands, barely older superiors, and much to learn. Having been through medical school and some training, some of us were accustomed to a facsimile of this living situation. Taking myself back to 18, just out of high school, and immersing in a world at war many miles away, I transposed myself during reading to 50 years ago.

Dr Miller writes conversationally, not only telling the story, but polishing the details with quotations and vivid pictures. He arranged his 2-year story in staccato chapters, each a story in itself, each connecting to the rest by having a sibling-like common ancestry. From the induction physical, boot camp sergeant routine, embarkation to Europe, foxhole accommodations, and the quick maturation to soldier from toy gun holder, the author paints the picture of the man now, not the adolescent,

ready for the test. Friends by juxtaposition, and authority figures by the draft, stream through the book, their names remembered in the epilogue with fondness. Such poignant parts as when death happens, when death is defied, and when the dreaded telegrams are not as bad as expected, keep the perspective that war is hell. Even wounded and out of action, the author recounts his medical experience with a perspective interesting now that he is a physician. When victory happens, winding down is certainly easier, but no less informative, than the beginning.

After finishing my reading and taking measure of what had happened to Dr Miller, I considered more current times. For those of us embroiled in the Vietnam era, facing that war and those politics, reading this distillation of one soldier's experience felt satisfying. Dr Miller speaks to all of us with that sympathetic, yet learned voice, that given the same circumstances, we too would have faced these challenges, like our medical training, with courage.

Stephen Z. Smith, MD
Book Review Author

Editor's Note — Milton F. Miller, MD, is a Louisville internist, a Kentucky Medical Association member, and has served on the Board of Editors of The Journal of the Kentucky Medical Association since 1976.

The Healing Place



Ruth Ryan

In 1980, one doctor, Will W. Ward, MD, started giving free medical service at a small homeless shelter operated by Father John H. Morgan. Other physicians and their spouses became involved in administration and service, so it was natural that in 1989 the Jefferson County Medical Society Outreach Program, Inc took title to and began to operate on an official basis the Morgan Center, later named The Healing Place (THP). The Healing Place, the largest homeless shelter in Louisville, is an innovative medical and social outreach to the homeless, the hungry, substance abusers and the impaired; its goal is to attract those so afflicted into a program of rehabilitation and recovery that will sustain their desire and will to recover and build a meaningful and self-sufficient life.

The 36-member Board of Directors is composed of physicians and Alliance members (45%) and other professionals and leaders in the business community (55%). Over 75% of the operating funds for The Healing

Place have been contributed by physicians.

The Jefferson County Medical Society Alliance is a major supporter in the areas of fund-raising, holiday food preparation and service. Its Healing Place Committee, chaired by past-president Angela (Mrs J. Roy) Watson, is the current link in a long chain of dedicated volunteers. The names of Alliance members who have given so generously of their time and effort would be too long to list here, but I'd like to pay tribute to the following presidents of the JCMS Alliance and chairpersons of the Morgan Center/Healing Place committees: Elizabeth (Mrs Richard) Allen; Barbara Bennett (Mrs Bernard Bruenderman; Alice (Mrs John) Cowley; Angela (Mrs Bob M.) DeWeese; Mary (Mrs Robert) Falk; Rose (Mrs Hoyt D.) Gardner; Carol (Mrs Robert) Goodin; Gloria (Mrs Larry J.) Griffin; Toni (Mrs James T.) Linville; Linda (Mrs Norman) Miller; Norma (Mrs Charles R.) Oberst; Marie (Mrs J. Matthew) Schwab; Cheryl (Mrs James M.) Van Daalen; Cathleen (Mrs Will W.) Ward; and Margaret (Mrs A. Franklin) White. Those not mentioned here have earned along with those who are mentioned the gratification of a job well done — straight from the heart to those in need of help!

The components of the Healing Place program are:

- A 115-bed emergency shelter for homeless men at 1020 West Market Street, Louisville;
- A 25-bed sobering-up center for men across the street at 1017 West Market Street;
- A Men's Recovery Program providing accommodations for 85 participants at the above locations;

- A 5-bed sobering-up center for women opened in 1995 at 720 East Oak Street, Louisville; and
- A Women's Recovery Program providing accommodations for 11 participants at the above location.

The Healing Place serves an average of 225 individuals per day via the emergency shelter, sobering-up centers and recovery programs with meals, lodging, medical and other services. The Healing Place provides per month approximately 23,000 free meals and 6,500 clean-linen beds. Fifty or more people per week receive free medical care at the four clinics staffed by volunteer doctors and nurses. One of the unique features of The Healing Place is that the Recovery Programs are housed in the same locations as the homeless shelters and sobering-up centers. This meets the men and women at their points of need and makes the recovery process visible, doable, and attractive. Men and women staying at the overnight shelters or the sobering-up centers are encouraged to consider sobriety and drug-free living. They observe other individuals involved in recovery making major lifestyle and attitude shifts and see that it is possible to make those same shifts themselves.

The four Phases of the Recovery Program are:

- I. The Recovery Dynamics curriculum, based on the twelve steps of Alcoholics Anonymous;
- II. Development of marketable skills and finding permanent employment while living in "a half-way house";
- III. Continuing care for 18 months; criteria for participation are sobriety, rent, and attendance at a weekly House meeting; choice of living in "a three-quarter house";



IV: Independent living; participants in Phases III and IV are encouraged to be present at THP to serve as positive role models for those in Phases I and II.

THP staff includes: Jay P. Davidson, Executive Director; Chris Fajardo, Director of Programs; Karen Newton, Project Coordinator; and Anne Fajardo, Program Director for the Women's Facility.

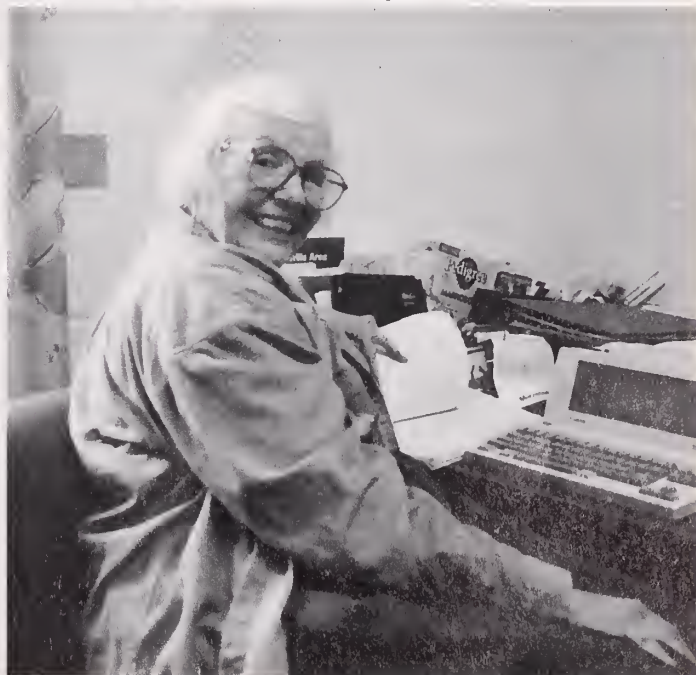
Our gratitude goes wholeheartedly to the physicians, their spouses and families, and the staff who dedicate their time and energy to this population that many have abandoned as hopeless.

Ruth Ryan
KMAA President

Left: FACETS, a national publication of the American Medical Association Alliance, featured an article on The Healing Place in one of their issues. This photo of Angela DeWeese and Gloria Griffin serving meals at THP appeared on the cover of that issue of FACETS.

Below, left photo: Betty Allen, Dick Allen, and Carol Goodin, L to R, included service at The Healing Place in their holiday celebration.

Right photo: Rose Gardner contributes many hours working at her desk at THP.





KMA Board of Trustees December Meeting



Top: The KMA Board of Trustees convened for their first meeting in the Board Room of the new office location.

Center: Emery A. Wilson, MD, Dean of the University of Kentucky College of Medicine, addressed the Board concerning Regional Partnerships.

Bottom: Lt Governor Steve Henry, MD, gave a presentation focusing on physicians' concerns.

The KMA Board of Trustees met on December 18-19, 1996, at the KMA Building in Louisville. Reports were given by the President; Secretary-Treasurer; Senior Delegate to the AMA; Alliance President; Chair, KEMPAC Board of Directors; Kentucky Medical Insurance Company; Commissioner for Health Services; and the Kentucky Board of Medical Licensure.

Lt Governor Steve Henry and Secretary John Morse gave presentations focusing on physicians' concerns with UNISYS, Medicaid claims, and the Medicaid Regional Partnerships. A progress report on the Regional Partnerships was presented by the University of Louisville School of Medicine and the University of Kentucky College of Medicine.

Appointments were made to the Task Force on Female Physicians, KMIC Board Nominating Committee, CME Committee, and the Committee on Insurance and Prepayment Plans. In further action, a nomination was submitted to the Governor for appointment to the Athletic Trainers Advisory Committee; and nominees were selected for service on the Kentucky Hospital Association Board of Trustees.

Legal Counsel updated the Board on the incorporation of the KMA Physicians Plan, Inc. and its decision not to pursue being a part of the bid on Kentucky Kare.

Additional reports were given by the Task Force on Comprehensive School Health Education, the Committees on National and State Legislative Activities, the Public Education Committee, the Committee on Medical Insurance and Prepayment Plans, and the Advisory Committee on Health Kentucky.

It was noted that the 1997 Annual Meeting will be held in Louisville September 14-18. The theme for the 1997 meeting is "Patient Advocacy: The Physician's Essential Role."

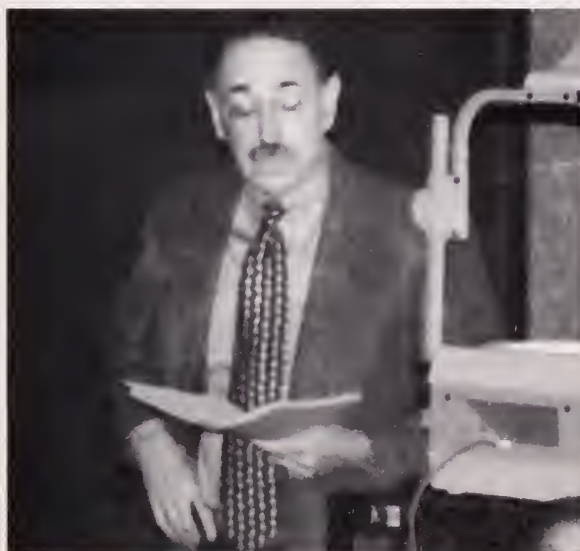
The next meeting of the KMA Board of Trustees was scheduled for April 16-17, 1997, at the KMA Building.



KMA President William H. Mitchell, MD, was presented a plaque of the October 1996 Journal cover which featured his photo.



William P. VonderHaar, MD, KMA's Secretary-Treasurer and KEMPAC Chair, reported to the Board.



Larry N. Cook, MD, presented a progress report on Regional Partnerships for the University of Louisville School of Medicine.

PEOPLE

J. David Richardson, MD, University of Louisville Department of Surgery, has been elected vice chairman-elect of the American Board of Surgery.

Karen W. Krigger, MD, Department of Family and Community Medicine at the University of Louisville, received first place in the workshop division at the Southeast Regional Society of Teachers of Family Medicine Conference in Jackson, MS, for "WINGS (Women and Children with HIV/AIDS Nurtured by Gifts of Healing and Supportive Care").

Jeffrey P. Callen, MD, a professor of dermatology at the University of Louisville, recently was elected to the board of directors of the Association of Professors of Dermatology.

Donald R. Kmetz, MD, Dean of the University of Louisville School of Medicine, has been honored for his administrative and academic leadership by being inducted into the Delphi Society, an honorary dental fraternity that recognizes excellence among faculty, administrators, and students associated with the School of Dentistry.

George Rodgers, MD, pediatrics, pharmacology, and toxicology, University of Louisville, recently was elected to a 2-year term as president of the American Association of Poison Control Centers. Prior to his appointment, Dr Rodgers served the association as a member of the board of directors and as a liaison to the American Academy of Pediatrics. He is also medical director of the Kentucky Regional Poison Center of Kosair Children's Hospital.

Impaired Physicians Program

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UPDATES

First PCR Test for Rapid Detection of *Mycobacterium Tuberculosis* Approved for Marketing by FDA

Roche Molecular Systems, Inc., recently announced that the first rapid diagnostic test for the detection of *Mycobacterium tuberculosis* (MTB) based upon the widely publicized polymerase chain reaction (PCR) was approved for marketing by the Food and Drug Administration. Leveraging the proven performance of PCR, the AMPLICOR® MTB Test can rapidly and reliably detect *M. tuberculosis* within hours as opposed to weeks with conventional culture methods, according to the report from Roche Diagnostics, US.

The report also stated, "With clinical trials that indicate 95% sensitivity and 100% specificity in this patient population, physicians can have more confidence early on in their treatment decisions. The packaging of PCR in a user-friendly kit for laboratories offers broad access to the technology's clinical benefits — high sensitivity and rapid test results — which we believe will lead to improved patient care."

New Cholesterol-lowering Medication Cleared for Marketing by FDA

Warner-Lambert has announced that LIPITOR (atorvastatin calcium) tablets, an HMG-CoA reductase inhibitor, or "statin," was cleared for marketing by the US Food and Drug Administration.

According to the report, LIPITOR dramatically reduces elevated LDL-cholesterol and is the only drug in its class specifically indicated for lowering both elevated LDL-cholesterol and triglycerides in patients with elevated cholesterol. The report also stated, "In multicenter,

placebo-controlled, dose-response studies in patients with high cholesterol, LIPITOR significantly reduced elevated LDL-cholesterol by about 40% to 60% across the dose range of 10 mg to 80 mg administered once daily. In addition, LIPITOR reduced triglycerides by approximately 20% to 40% across the dosage range."

FDA Clears New Treatment for Impotence

VIVUS, Inc has announced that it has received clearance from the US Food and Drug Administration to market MUSE® (alprostadil) urethral suppository for the treatment of erectile dysfunction.

According to the report, VIVUS conducted in the US a large multicenter study of a treatment for organic erectile dysfunction with 996 men and their partners participating in a three-month home-treatment protocol. After individual titration, approximately 65% of men on active drug had intercourse at least once compared to 19% on placebo. Among those who responded to therapy, 7 out of every 10 treatments with MUSE (alprostadil) resulted in sexual intercourse. Treatment efficacy was shown in all causes of erectile dysfunction studied: vascular disease, diabetes, surgery or trauma, and other organic conditions. Quality-of-life data also were collected which indicated that patients treated with MUSE (alprostadil) experienced significant improvement in emotional well-being, and patient-couples improved their relationships with one another. The most common side effect, mild and transient penile pain, occurred in 11% of administrations.

Three-Year Cycle on Mandatory CME Ended December 31, 1996

As required by the regulation 201

KAR9:310, mandatory CME for licensed physicians, 60 hours of CME must have been obtained by physicians over the three-year cycle from January 1, 1994-December 31, 1996. The Kentucky Medical Association has received numerous inquiries from physicians about where to send their record of attendance at continuing medical education courses.

The Kentucky Board of Medical Licensure will include a question on the 1997 Physician License Renewal Form for physicians to indicate if they have met the mandatory CME requirement. The Licensure Board is planning to conduct a random audit of physicians' CME records to determine if they have fulfilled the number of hours required. The Licensure Board has asked that physicians hold on to their CME records for three years and not send them to the Licensure Board unless requested to do so.

The new 3-year cycle for mandatory continuing medical education covers the period January 1, 1997-December 31, 1999.

New User Friendly Coding Manual Now Available Through NTIS

The latest version of the Health Care Financing Administration's *National Correct Coding Policy Manual for Part B Medicare Carriers* — Version 2.3 — is now available through the National Technical Information Service. Reflecting all code additions and deletions instituted by HCFA through September 30, 1996, this version of the manual has been redesigned to make it a more affordable and easier-to-use coding resource.

The paper copy manual will now be published on a quarterly basis and is available as an ongoing subscription through NTIS for \$260 a year. To subscribe, call the NTIS Subscriptions Department at 703/487-4650; quote order number PB97-

957600KCO.

To order a single issue of the manual in either copy or on CD-ROM, call the NTIS Sales Desk at 703/487-4650. Quote order number PB97-957601KCO for the paper copy manual; PB96-503172KCO for the CD-ROM. A handling fee is assessed for single issue purchases.

Physicians Beware of "Hold Harmless" Agreements with Managed Care Organizations

Today, many managed care organizations are being sued by patients on a wide variety of theories. Some plaintiffs claim the organizations do not exercise "reasonable care" in choosing physicians to participate in the organization. Others have claimed that the organization operates to save money at the expense of a patient and creates an atmosphere that promotes malpractice. Such potential liability on the part of the managed care organization is over and above any claim made against the physician for malpractice.

In an effort to avoid the costs of such liability, many managed care organizations are attempting to shift the costs of such liability to the physicians by inserting in their contracts certain language that will make the physician responsible for such costs. While doctors have always been responsible for the costs of liability that may stem from a malpractice claim (such costs usually being paid by the physician's malpractice insurance), physicians are now being told they must pay the costs of any action brought against the managed care organization. This issue is especially important to physicians because most liability insurance carriers do not cover physicians for the cost of the managed care organization's liability.

Physicians can look for

contractual language similar to the following:

The physician shall hold harmless, indemnify and defend the HMO . . . from any litigation costs, claims, judgments, liability and damages resulting from the medical care rendered to participants under this contract . . .

Physicians should look for language that makes them "solely responsible" and "exclusively responsible" for the medical care of the patients. Such language may be interpreted as placing the costs of the organization's liability onto the physician. Ideally, physicians should have their attorney review all contracts with managed care organizations and have the attorney negotiate to have the dangerous clauses removed. Such action may prevent a physician from having to pay out of his/her own pocket for the liability of the organization.

Rural Kentucky Medical Scholarship Fund, Inc Applications Now Available

Applications are now being accepted by the RKMSF for the 1997-98 academic year. The Fund has been in existence since 1945-46 and is designed to financially assist those medical school students who are willing to practice primary care medicine in designated rural areas of Kentucky upon graduation.

Applications are welcomed from residents of Kentucky who have been admitted to the U of L or U of K medical schools. The Fund will loan up to \$12,000 per year to those students selected to participate. For consideration, all applications must be received at the RKMSF office by **April 1.**

For an application or for more information about the RKMSF, please contact RKMSF staff at 502/426-6200.

Medicare Deductibles and Premiums Announced for 1997

The Department of Health and Human Services announced that Medicare's Part A deductible will increase \$24.00 to \$760.00. The Part B premium will increase \$1.30 to \$43.80 per month.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

Thomas N. Epperson, III, MD —IM
142 Edgewood Rd, Middlesboro
40965
1992, U of Louisville

Boone

Ruth V. Hussey, DO —IM
856 Moonstone Ct, Crescent Springs
41017
1992, U of Health Sciences,
Kansas City

Bourbon

Regina M. Raab, MD —N
1650 Jackstown Rd, Paris 40361
1986, Northwestern

Campbell

Rita J. Watkins, MD —FP
3104 Dixie Hwy Ste 204, Erlanger
41018
1986, U of Cincinnati

Calloway

C. Brent Boles, MD —OBG
305 South 8th, Murray 42071
1992, U of Louisville

Christian

Randal L. Fielder, MD —FP
1610 S Main St, Hopkinsville 42240-

6161
1983, U of Monterrey

Clark

Richard A. Chamberlain, MD —OBG
1118 McCann Dr, Winchester 40391
1977, U of Alberta

Daviess

Arif Mohammad Omar, MD —C
815 E Parrish Ave, Owensboro 42303
1983, Dow, Pakistan
Shirishkumar N. Patel, MD —IM
3274 Steeplechase, Owensboro 42303
1989, U of Baroda, India

Fayette

William B. Caudill, MD —NEP
2161 Mangrove Dr, Lexington 40513
1985, U of Louisville
Gregory J. Davis, MD —PTH
100 Sower Blvd, Ste 202, Frankfort
40601
1985, U of Tennessee

Floyd

Mazen Jaafar, MD —PD
4954 KY Route 321, Prestonburg 41653
1979, Aleppo U, Syria

Graves

Miranda P. Gaw, MD —IM
203 Golf Cart Dr, Mayfield 42066
1982, U of Rangoon, Burma
Christina M. Koonce, MD —FP
USS Blue Ridge LCC 19, FPO AP
96628-3300
1994, Tulane

Hardin

Carmela G. Osborne, MD —GP
1346 Kingswood Way, Radcliff 40160
1993, U of Kentucky

Harrison

Dwight E. Lewis Jr, MD —IM
PO Box 575 Millersburg Pike,
Cynthiana 41031
1982, U of Louisville

Henderson

Scott A. Watkins, MD —IM

1680 Schuette Ln, Henderson 42420
1993, U of Louisville

Jefferson

Joseph J. Creely, III, MD —OTO
1169 Eastern Pkwy, Ste 1234,
Louisville 40217
1990, Vanderbilt
Timothy G. Givens, MD —PD
2211 Village Dr, Louisville 40205
1987, Vanderbilt

Jessamine

James Matthew Hartford, MD —S
1126 Baker Ln, Nicholasville 40356
1989, Dartmouth

Kenton

John J. Castaneda, MD —FP
4341 Winston Ave, Covington 41015
1983, Ohio at Toledo
Jeffrey T. Janning, MD —PD
230 Thomas More Pky, Crestview
Hills 41017
1984, U of Cincinnati
George Kranias, MD —OPH
2230 Auburn Ave, Cincinnati 45219
1968, U of Thessaloniki, Greece
Keith J. Millay, MD —FP
104 Farmcrest Ct, Lakeside Park 41017
1987, U of Kentucky
Sandra M. Syfert, MD —FP
4341 Winston Ave, Covington 41015
1992, U of Cincinnati

Knox

Richard A. Carter, MD —FP
PO Box 1150, Barbourville 40906
1993, U of Kentucky
Paul C. Pedersen, MD —FP
602 Knox St, Barbourville 40906
1992, U of Toronto

Lawrence

Jeremy C. Klein, MD —FP
PO Box 730, Louisa 41230
1982, U of Maryland

Letcher

Padubidri Chandrashekar, MD —IM
105 Vermillion Ave, Whitesburg 41858
1979, Bangalore, India

McCracken

Fred S. Mushkat, MD —EM
4500 Quail Hollow Dr, Paducah 42001
1976, Ohio State

Marion

Ewa F. Grzeszczak, MD —R
130 Country View Dr, Lebanon 40033
1984, Wroclaw, Poland
Marek J. Grzeszczak, MD —PD
130 Country View Dr, Lebanon 40033
1984, Wroclaw, Poland
Steven E. Thomas, MD —S
496 W Main St, Lebanon 40033
1991, U of Louisville

Perry

James A. Chaney, MD —GP
306 Morton Blvd, Hazard 41701
1991, Marshall

Pike

Tomas Q Lim, MD —IM
59 Thacker Rd, Apt 1, Pikeville 41501-3021
1988, U of Santo Tomas, Philippines

Pulaski

Robert R. Cunningham, MD —OBG
104 Hardin Ln, Somerset 42503
1980, U of Cincinnati
Zeljko Radic, MD —AN
113 Wood Ct, Somerset 42501
1978, U of Belgrade, Yugoslavia

Rowan

Jerome H. Waller, Jr, MD —FP
1080 Rodburn Hollow Rd, Morehead 40351
1992, U of Kentucky

Whitley

Patricia A. Doncaster, DO —FP
408 Sycamore St, Williamsburg 40769
1900, C of Osteopathic, Kirksville
Thomas J Doncaster, DO —FP
408 Sycamore St, Williamsburg 40769
1992, C of Osteopathic, Kirksville

Woodford

Michele M. Welling, MD —IM
506 S Main St, Versailles 40383

1992, U of Kentucky

**In Training
Campbell**

Pamela C. Heston, MD —FP

Jefferson

Terry Cohen, MD —PD
Michael N. Elleman, MD —EM
James R. Porter, MD —PD

DEATHS

Gaston N. Maya, MD
Louisville
1920-1996

Gaston N. Maya, MD, a retired family physician, died December 11, 1996. A 1947 graduate of the University of Havana School of Medicine, Dr Maya was a life member of KMA.

George B. Boeckmann, MD
Horse Cave
1938-1996

George B. Boeckmann, MD, a family physician, died December 11, 1996. Dr Boeckmann was a 1968 graduate of the University of Louisville School of Medicine and an active member of KMA.

William W. Spalding, MD
Louisville
1927-1996

William W. Spalding, MD, a retired family physician, died December 19, 1996. Dr Spalding was a 1954 graduate of the University of Louisville School of Medicine and a life member of KMA.

Thelma S. Manlavi, MD
Hopkinsville
1930-1997

Thelma S. Manlavi, MD, a psychiatrist, died January 1, 1997. A 1955 graduate of the University of Santo Tomas, Philippines, Dr Manlavi was an active member of KMA.

Carolyn D. Blair, MD
Louisville
1962-1997

Carolyn D. Blair, MD, an internist, died January 1, 1997. Dr Blair was a 1986 graduate of the University of Louisville School of Medicine and an active member of KMA.

1997 KMA Practice Management Seminars

FEBRUARY

How to Run a More Profitable Practice

Feb 25 - Lexington
Feb 26 - Louisville

How to Get Started in Medical Practice

Feb 27-28 - Louisville

MARCH

Coding & Reimbursement

Mar 19 - Lexington
Mar 20 - Louisville

APRIL

Gearing Up for Retirement

April 23 - Louisville

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information, please contact the
KMA Office at (502) 426-6200.*

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Better Back Store	73	Lexington Diagnostic Center	Cover IV
Dean Witter	74	MP System 2000	62
Financial Architects	73	Medical Protective Co	63
Health Volunteers Overseas	Cover III	North American Medical Golf Association	73
Impaired Physicians Program	62	PIE Mutual Insurance Company	54
		US Air Force	Cover II

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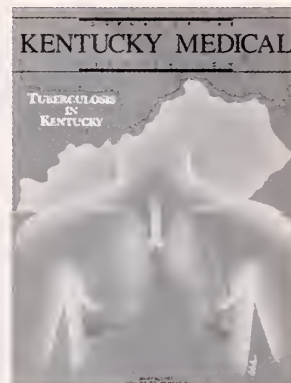
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COVER: Current guidelines for empiric therapy for pulmonary tuberculosis depend on the presence of INH or INH and rifampin resistance (MDRTB) in the community. A study to determine susceptibility of MTB in Kentucky and to consider which therapeutic modality for empiric therapy should be followed begins on page 99.
Artwork by Lee Wade of Eminence, KY

COVER STORY	Tuberculosis in Kentucky: Current Recommendations for Empiric Therapy <i>Barbara Wojda, MD; Sunket Ahkee, MD; Nathan Uyamadu, MD; Kahled Jouja, MD; Julio A. Ramirez, MD</i>	99
SCIENTIFIC	A Rare Uterine Tumor Presenting as Deep Venous Thrombosis <i>Heather Hoffmann Theurer, MD; Dennis M. O'Connor, MD</i>	102
SPECIAL ARTICLE	The Practicality of Using the SMAST and AUDIT to Screen for Alcoholism Among Adolescents in an Urban Private Family Practice <i>Alexandra I. Foster; Richard D. Blondell, MD; Stephen W. Looney, PhD</i>	105
EDITORIAL	Human Guinea Pigs — Protecting Human Subjects <i>Richard L. Miller, DDS, PhD</i>	109
ASSOCIATION	<i>Monitoring Medicine News</i>	95 117
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Classified Information for Authors Letters to the Editor	93 122 112 121 104 115

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Art or Science?

We have been confused as to whether medicine is an art or science for a number of years. Terms such as Medical Arts Building and Health Sciences Center abound in our environment. If we consider our pre-medical education, certainly our training is weighted toward sciences. Recently, my daughter and I discussed courses we would have liked to take at college but could not schedule. We can all remember the stress as we competed in the required courses, hoping we would be selected for a medical school class. Perhaps this competition is why we as physicians do not function well as a group. Students today have similar required courses and related stress.

As I began to think about my pre-medical education and other subjects I would have studied, I remembered my schedule always seemed to be full with biology, chemistry, comparative anatomy, physics and etc. I had little time to study the arts and history. How useful have all those courses been? I remember Dr Paul Sears, a chemistry professor at University of Kentucky, telling me how important it was to learn to balance equations. He said that if I were fortunate enough to be accepted in medical school, this would be an invaluable skill. Fortunately, I have never been asked to balance a chemical reaction since I left his class. There are many skills developed in my premed days which I have not been called upon to use in my practice: using a slide rule, dissecting cats, sharks and various animals, naming phylum, genus and species of innumerable organisms, just to name a few.

I have been asked, however, to interact with people from all walks of

"The broadening of our experience in literature, the arts, and history would not only benefit us personally but might improve our profession, its image, and our patient care interactions."

life and to understand their points of view and difficulties which encumber their daily lives.

As chairman of the Kentucky Medical Association Board of Trustees, I have been required to use personal and political skills to interact with my peers as well as represent them and our patients in the Kentucky political arena. Skills of dissection of small animals and using the slide rule have been of little use.

I realize medical schools' admission committees must have standard difficult core courses to compare potential candidates. The ability to critically evaluate scientific data is a crucial skill for physicians. But our profession must broaden its horizons by encouraging diversity of study among premedical students as well as physicians.

Recently, Nancy Roberts Trott, a reporter for the Associated Press, reported on a Dartmouth program to study literature. Students felt that this was a valuable course, as it helped them to develop perspective on life and become more compassionate physicians. Dr Jonathan Ross, a



Harry W. Carloss, MD

member of the Dartmouth Faculty, feels that teaching medical students compassion through literature can help salvage the doctor/patient relationship. We are gradually recognizing the value of non-scientific education.

According to the Association of American Medical Colleges, about one third of the medical schools have some sort of literature program. The American College of Physicians has added a listing of literature of interest to the popular medical library for internists featured in the Annals of Internal Medicine.

We cannot all develop writing and communication skills like Michael Crichton, MD. The broadening of our experience in literature, the arts, and history would not only benefit us personally but might improve our profession, its image, and our patient care interactions.

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AMA Introduces "Anti-Gag" Legislation

On February 5, legislation was introduced in the United States House of Representatives which would eliminate "gag clauses" and "gag practices" in all health care plans. This legislation, HR 586, the "Patient Right to Know Act of 1997," was introduced by Representatives Greg Ganske (R-IA) and Ed Markey (D-MA).

The AMA/KMA applauds the sponsors for introducing this important and timely legislation at the beginning of the 105th Congress. We believe that establishing a federal standard to protect medical communications between patients and their physicians will return to patients the ability to make informed decisions regarding their health care needs. Although voluntary efforts to overcome "gag clauses" offer the appearance of reform, the AMA/KMA believes that this legislation is significant because it will put in place the force of law to address this serious public concern.

Over a year ago, the AMA called upon all managed care plans to immediately cancel gag clauses in their contracts with physicians. To their credit, some health plans have done just that. Unfortunately, not all health plans have acted as responsibly. The AMA believes that health plans that voluntarily remove "gag clauses" and eliminate "gag practices" should be commended. However, without federal legislation, many patients receiving care from those plans that do not — or will not — make these changes are placed in peril every day. To this end, we are pleased that the "Patient Right

To Know Act of 1997" will protect patients by eliminating both "gag clauses" and "gag practices" in all health care plans.

The AMA will work with Congress and the Administration to ensure that patients receive all the information they need to make informed decisions about their health care. While physicians have a legal and ethical duty to provide patients with all the information they require, we believe that patients should no longer fear that third-party payors could potentially interfere with a patient's ability to receive crucial medical information.

Lobbying entities representing irresponsible health plans which are not interested in seeing this legislation enacted into law have already begun a campaign intended to convince the Congress that this type of legislation is unnecessary. They argue that such laws are merely an intrusion into the private contracting practices between these plans and physicians. **In reality, as you know, such practices do nothing more than undermine the sacred trust between a physician and a patient.**

It is critically important that physicians contact their Congressional representatives to seek co-sponsors and support for this important legislation. **Enactment of this legislation will be a high priority for the AMA and they will be pursuing as many co-sponsors as possible in order to heighten the likelihood of this bill's passage.**



Medicaid Managed Care Partnerships

With the continuing pressure to decrease the federal budget deficit, the Federal Government is looking to many government programs for savings over the next few years. One program that has continually caught the interest of lawmakers is the Medicaid program. President Clinton has proposed capping the amount of money a state may get for Medicaid. Many states are trying new and different approaches to save money in the Medicaid system in the face of such spending cuts. In order for a state to implement such changes to its Medicaid system, the state must receive a "waiver" from the Federal Government. Many states have requested, and been granted, such waivers and have instituted reforms centered around placing Medicaid into managed care in order to save money.

Kentucky received a waiver from the Federal Government to institute sweeping changes into its Medicaid system. Kentucky's proposal is unlike any other proposal submitted by a state. Kentucky is attempting to divide the state into eight separate Regions and have each Region separately contract with the state to provide Medicaid services. The contract with the state would be made with either an entity known as a "Partnership," or, a private managed care entity (ie, HMO). Once a Region forms a Partnership or contracts with a private managed care entity, the current KenPAC system will be replaced by the new system.

A Partnership will be an entity formed by providers in a Region that contracts with the state and

coordinates the program in their Region. The idea is for the state to pay the Partnership a monthly amount and have the Partnership contract with various providers in the Region to give services to the Medicaid population. How these contracts with various providers are obtained and written is up to the Partnership, as well as how providers will be paid for their services.

The Regions encompassing Lexington and Louisville (Regions 5 and 3 respectively) are leading the way in establishing Partnerships. Each of these Partnerships is centered around a University and each has designed a system to contract with providers in their respective Regions. It is still unclear how much risk providers will have to assume to contract with the Partnerships; but a recent implementing regulation submitted by the Cabinet for Health Services places a great deal of risk on individual providers. Providers should contact their Regional representative and discuss with them how the Partnership will be implemented in their Region and how providers will be reimbursed for their services. Providers should also find out how much risk they will have to assume in order to contract with the Partnership.

Should a Partnership not be established in a particular Region, the state has said it will bid the Medicaid services out to private managed care entities. This may result in an HMO providing all of the Medicaid services in a given Region.

The KMA Board of Trustees

recently adopted the following policy concerning the new Medicaid Managed Care initiative.

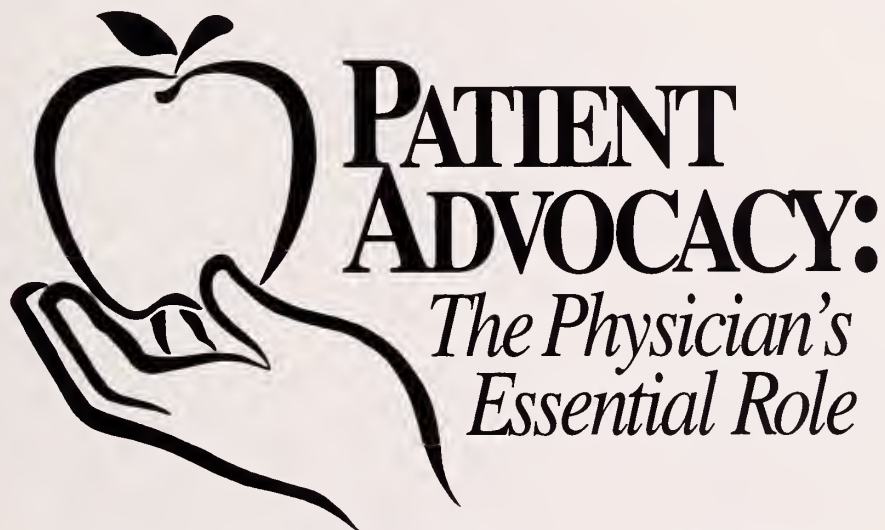
KMA recognizes the Cabinet's exploration of different ways to administer the Kentucky Medicaid program. KMA's primary concern is that patient care not be adversely effected by a new methodology. Inherent in current proposals to privatize Medicaid are increased administrative and overhead costs, a consideration of return on investment, and the creation of a new bureaucracy. Because of these and other concerns, KMA suggests that the Cabinet limit implementation of privatization methodologies to one, or perhaps two, pilot projects. Based upon activities to date, it appears such a pilot project would be centered in either Region 3 or 5, or both. The Association further suggests that while other areas of the state may wish to develop an infrastructure capable of supporting a managed care partnership, actual implementation of this strategy should be held in abeyance until the pilot projects clearly demonstrate their value to the Commonwealth.

As the pilot programs attempt to demonstrate their effectiveness, we suggest that the current KENPAC program be enhanced; additional Medicaid recipients could be placed under KENPAC and this program could be used as a reference point for comparison

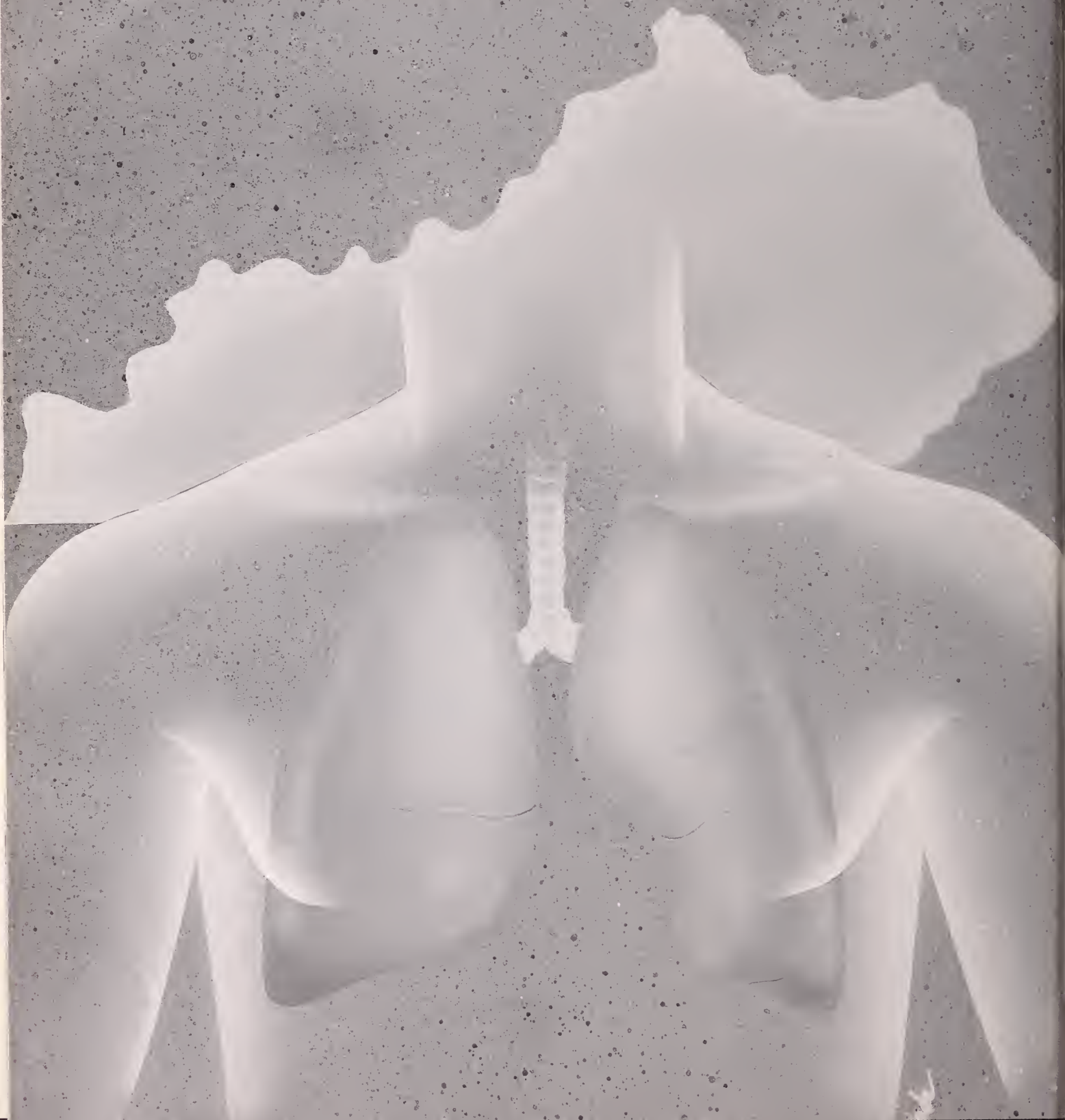
with efficiencies sought in the pilot programs. Currently, there is very little utilization review in KENPAC, and as a first step, we suggest enhancement of utilization management efforts. This might improve KENPAC to a level that privatization becomes unnecessary.

In summary, Kentucky Medical Association is suggesting a moratorium on privatization projects until the pilot project or projects alluded to earlier demonstrate positive results. KMA believes the regulation should be modified accordingly.

The Medicaid system is changing and providers must obtain as much information as possible to decide how best to adapt to the changes. Reimbursement, assumption of risk, and other issues must be explored before providers decide how best to proceed in the new Medicaid system.



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Tuberculosis in Kentucky: Current Recommendations for Empiric Therapy

Barbara Wojda, MD; Sunket Ahkee, MD; Nathan Uyamadu, MD;
Kahled Jouja, MD; Julio A. Ramirez, MD

Current guidelines for empiric therapy for pulmonary tuberculosis depend on the presence of INH or INH and rifampin resistance (MDRTB) in the community. The objective of this study was to determine the susceptibility of MTB in Kentucky and to consider which therapeutic modality for empiric therapy should be followed. The total number and rate of pulmonary tuberculosis was analyzed and compared to national trends. Data of susceptibility were analyzed based on INH and rifampin resistance. There were 4753 cases of TB in Kentucky between 1984 and 1994. Data of susceptibility were available from 1989 through 1994.

Total number of MTB decreased by 14% in 1994 from 1993 but resistance to INH doubled from 3.2% to 7.6%. MDRTB increased from 1.2% to 3.2%. INH resistance >4% on initial isolates was recorded in Allen, Bell, Estill, Fleming, Jefferson, Kenton, Knott, Oldham, Rowan, and Wolfe counties. Outbreak of MDRTB was documented in Estill county. There was no HIV infection documented in this group. In the rest of the state, INH resistance was <4%. In counties with INH resistance <4%, empiric therapy for TB should include 3 drugs: INH and rifampin for 6 months and PZA added for the first 2 months. In counties with INH resistance >4%, empiric therapy should include 4 drugs: INH, rifampin, PZA, ethambutol or streptomycin. In Estill county with documented MDRTB, empiric therapy should include 5 to 6 drugs: INH, rifampin, PZA, ethambutol, streptomycin, and amikacin. If INH and rifampin resistance is present, the therapy should include at least 3 drugs to which the organism is sensitive. This regimen should be continued until sputum cultures become negative. Further therapy should be continued with 2 drugs for 1 year. HIV infected patients constitute a separate category and therapy for them should be individualized.

After decades of decline in the United States, tuberculosis (TB) is resurgent. The largest outbreaks of TB were documented in New York, California, Texas, and Florida.¹ Factors associated with increased incidence of TB are: homelessness, crowded living conditions, HIV infection, and inadequate access to medical care. Prison inmates, migrant farm workers, and immigrants from endemic areas are also at increased risk for developing TB.² With increased incidence of pulmonary TB, resistance to INH and rifampin has been rising rapidly. Multi-drug resistant tuberculosis (MDRTB) is defined as resistance to at least two drugs, most commonly INH and rifampin. MDRTB in the US occurs in two types of patients: those with inadequately treated prior TB, and those exposed to MDRTB in outbreak settings. This latter group consists largely of immunosuppressed patients infected with HIV.

According to the CDC, risk factors for primary resistance include exposure to a patient who has drug-resistant tuberculosis, being from a country with high prevalence of drug resistance, and greater than 4% primary resistance to INH in the community.³ Secondary resistance occurs in a patient who has been treated in the past and was noncompliant to medications. Even though cases have been reported in most states, MDRTB is a localized problem. One report stated that geography is the strongest risk factor for development of MDRTB. For example, in 1991 New York City accounted for more than 60% of all the reported cases of MDRTB.² This created management problems, and guidelines for empiric therapy were established.⁴

Current guidelines for empiric therapy of MTB depend on the prevalence of multi-drug-resistance in the community. In areas with low INH resistance (<4%) the empiric therapy should include 3 drugs. In areas with higher INH resistance

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Tuberculosis in Kentucky

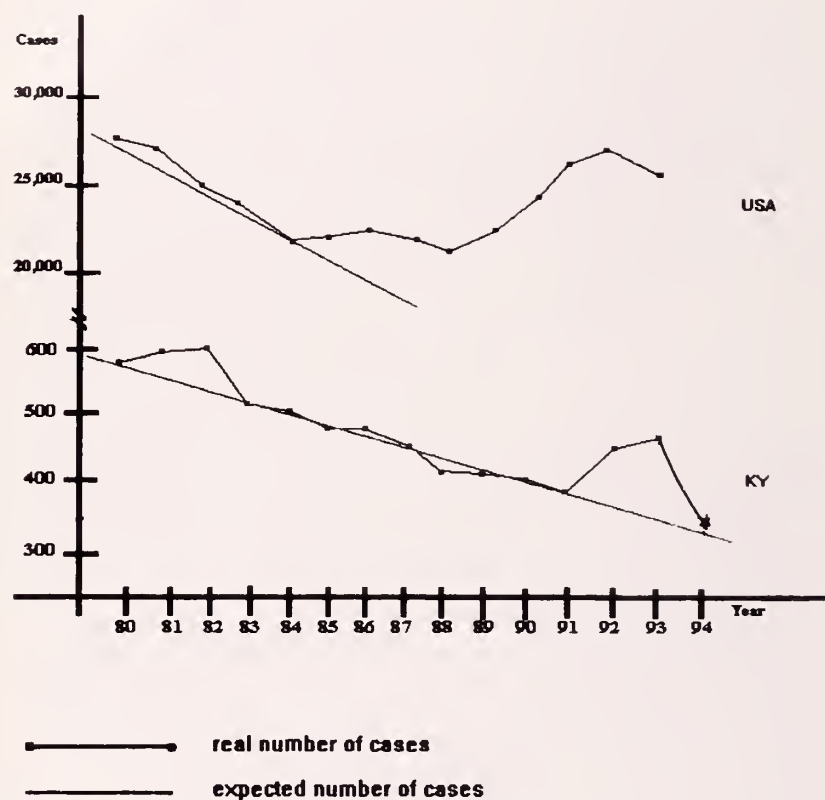


Fig 1 — Total number of cases in the US and KY per year.

Table 1. Total number of MTB and rate per 100,000 population

Year	KY cases	KY case rate	US cases	US case rate
1980	570	15.6	27,749	12.3
1981	596	16.6	27,373	11.9
1982	605	16.5	25,520	11.0
1983	523	14.1	23,846	10.2
1984	510	13.7	22,255	9.4
1985	463	11.4	22,201	9.3
1986	464	11.4	22,768	9.4
1987	421	11.3	22,517	9.3
1988	384	10.3	22,436	9.1
1989	380	10.2	23,495	9.5
1990	361	9.8	25,701	10.3
1991	347	9.3	26,283	10.4
1992	402	10.7	26,676	10.8
1993	404	10.7	25,287	9.8
1994	347	9.2	24,361	9.6

(>4%) the empiric therapy should consist of 4 drugs. If multi-drug-resistant tuberculosis (MDRTB) is documented in the community, the treatment should include 5 to 6 drugs. The objective of this study was to determine the susceptibility of *Mycobacterium tuberculosis* in Kentucky and to consider which therapeutic modality for empiric therapy should be followed.

Materials and Methods

The total number and rate of pulmonary tuberculosis was analyzed and compared to the national trends. All new cases of MTB susceptibility between 1984 and 1994 from the state health department records were reviewed.⁵ Data of susceptibility were analyzed based on INH and Rifampin resistance. If an organism was resistant to both drugs, it was considered as MDRTB. All patients with MDRTB were analyzed in regards to economic status, access to medical care, homelessness, geographical location, illicit drug use, alcohol abuse, and HIV infection.

Results

There were 4753 cases of pulmonary tuberculosis in Kentucky between 1980 and 1994. The total number of cases in the US and KY per year is depicted in Fig 1. It demonstrates the increased number of TB cases nationally since 1985. In Kentucky, this outbreak started in 1991. In 1994 there was a marked decrease of total number of cases. The total number of TB and rate per 100,000 population is depicted in Table 1. Data of susceptibility were available from 1989 through 1994. Total number of MTB cases and susceptibility in 1993 and 1994 are summarized in Table 2. Total number of MTB decreased by 14% in 1994 from 1993, but resistance to INH doubled from 3.2% to 7.6%. MDRTB increased from 1.2% to 3.2%. INH resistance greater than 4% on initial isolates was recorded in Allen, Bell, Estill, Fleming, Jefferson, Kenton, Knott, Oldham, Rowan, and Wolfe counties. Outbreak of MDRTB was reported in Estill county. The distribution of *Mycobacterium tuberculosis* sensitivity in 1994 is depicted in Fig 2. All nine patients with MDRTB were alcoholics and noncompliant to antituberculous medications. All have adequate access to medical care and no one was homeless in this group. There was no HIV infection documented in MDRTB patients. There was only one foreign-born MDRTB patient and two subsequent secondary cases.

Discussion

There are three different regions of MTB susceptibility in Kentucky: Estill county with outbreak of MDRTB; Allen, Bell, Fleming, Jefferson, Kenton, Knott, Oldham, Rowan and Wolfe counties with INH resistance >4%; and the rest of the state with INH resistance <4%. The empiric therapy for pulmonary tuberculosis in Kentucky depends on the regional sensitivity pattern.

In counties with INH resistance <4% the empiric therapy should include 3 drugs: INH, rifampin for 6 months, and PZA added for the first 2 months. In counties with INH resistance >4% the empiric therapy should include 4 drugs: INH, rifampin, PZA ethambutol or streptomycin. If INH resistance is documented, isoniazid should be discontinued and PZA, rifampin, and ethambutol be continued for the entire 6 months. In Estill county with outbreak of MDRTB the empiric therapy for MTB should include 5 to 6 drugs: INH, rifampin, PZA, ethambutol, streptomycin, or amikacin. At least 2 agents should be used to which there is demonstrated susceptibility in the community. If INH and rifampin resistance is confirmed, therapy should include at least 3 drugs to which the organism is sensitive. This regimen should be continued until sputum cultures become negative. Further therapy should be continued with 2 drugs for another 12 months after sputum cultures convert to negative.

Our study indicates that Kentucky is not immune to drug resistant tuberculosis. The major risk factor for developing resistance in Kentucky is alcoholism and noncompliance to medications. It is critically important to identify high risk patients and provide close supervision and follow-up. If alcoholism or noncompliance is suspected, close observation in a form of direct observed therapy (DOT) should be used from the beginning of treatment. All patients should be asked routinely about adherence to therapy. Sporadic pill counts and urine tests can be used to monitor drug ingestion.

In conclusion, due to diversity of INH and rifampin resistance in Kentucky, the empiric therapy for pulmonary tuberculosis should depend on the regional sensitivity pattern. In Estill county the regimen should include 5 to 6 drugs; in Allen, Bell, Fleming, Jefferson, Kenton, Knott, Oldham, Rowan and Wolfe counties, it should include 4 drugs; and in the rest of the state 3 drugs.



Fig 2 — Distribution of Mycobacterium tuberculosis sensitivity in Kentucky in 1994.
black area — MDRTB
grey areas — INH resistance >4%
white areas — INH resistance <4%

Table 2. Total number of cases and susceptibility in 1993 and 1994

	1993	1994
Total Cases Reported	404	347
Total Culture Confirmed	243	182
Total (%) INH Resistance	8 (3.2%)	14 (7.6%)
Total (%) INH + Rifampin Resistance	3 (1.2%)	6 (3.2%)

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A Rare Uterine Tumor Presenting as Deep Venous Thrombosis

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A 63-year-old woman with a rare pelvic tumor is presented as an example of an unusual clinical complaint for this neoplasm. The patient's original complaint was lower leg pain with swelling. Deep venous thrombosis was identified and ancillary studies confirmed the presence of a pelvic mass. Histopathologic diagnosis was a uterine tumor resembling ovarian sex cord tumor. This case illustrates the importance of considering a diagnosis of a pelvic tumor with a complaint of deep venous thrombosis.

Deep venous thrombosis arising in a lower extremity usually results from local conditions affecting the vein site. The following represents a case where the reason for lower extremity thrombosis was an abdominal-pelvic tumor remote from the affected area.

Case Report

A postmenopausal 63-year-old woman was admitted to the hospital with left leg swelling and pain on ambulation.

The patient had lost 10 pounds in the 12 months prior to admission and had recently become lethargic. She denied any recent immobilization. She had experienced occasional vaginal bleeding for the year prior to admission, but Papanicolaou smears had been negative in the past. The patient had smoked one pack of cigarettes daily for 25 years. She had been taking Dyazide for treatment of hypertension.

On physical examination the patient was in no distress. Head and chest examinations were unremarkable. Examination of the abdomen demonstrated a nontender, firm, midline abdominal mass. Bowel sounds were present. On speculum examination, clotted blood was found in the va-

gina and the cervix was deviated anteriorly. Bimanual examination demonstrated an enlarged mobile uterus (16 weeks gestation size). Arising from the posterior uterus was a tender mass that extended into the cul-de-sac. The adnexae could not be identified. The left leg was edematous but nontender. Homan's sign was negative.

The complete blood count revealed a hemoglobin of 11.2 gm/dl. Arterial blood gases revealed a pH of 7.47, a pO₂ of 64%, and a pCO₂ of 35%. Serum electrolytes, PT and APTT were within normal limits. The Papanicolaou smear was within normal limits but limited by air drying and partially obscuring blood. Endometrial biopsy demonstrated fragments of hypercellular tissue suggestive of leiomyoma.

Doppler examination revealed a clot in the common deep and superficial femoral veins and proximal saphenous vein. A diagnosis of deep venous thrombosis was made, and the patient was placed on anticoagulant therapy. Computed tomography revealed a mass in the inferior aspect of the liver, retroperitoneal adenopathy, and multiple pulmonary nodules. Rigid proctoscopy demonstrated no rectal lesions.

At the time of surgery, examination under anesthesia confirmed the pelvic mass. On exploratory laparotomy, a uterine tumor was found that involved the left tube and ovary, extended into the left ovarian and external iliac veins, and encircled the left ureter. Tumor nodules were found in the mesentery. While the inferior surface of the liver was thickened, nodularity was not noted. The colon, stomach, and omentum were normal.

A diagnosis of poorly differentiated adenocarcinoma was made on frozen section. Total abdominal hysterectomy and bilateral salpingo-oophorectomy with radical tumor debulking were performed. Tumor and clot were removed from the left external iliac vein. A left ureteral stent was placed.

Gross

The uterus weighed 913.6 gms. The uterine cavity was distended with a friable, hemorrhagic tumor mass. The tumor infiltrated the wall of the myometrium and extended into vascular spaces. Separate from the tumor within the myometrium was a 5 cm well-circumscribed, firm mass. The endometrium was unremarkable. The $9 \times 5 \times 5$ cm enlarged left ovary contained numerous solid tumor nodules.

Microscopic

In the uterus, the neoplasm infiltrated between fascicles of normal uterine myometrium. Lymphovascular space invasion was present. The tumor had a biphasic morphology; anastomosing trabeculae of epithelioid cells were focally present in a predominant spindle-cell stroma (Fig 1). The epithelioid cells were characterized by an abundant eosinophilic cytoplasm with ovoid, cleared nuclei that contained eosinophilic nucleoli. Nuclear pleomorphism ranged from moderate to marked. Nuclear grooves were not noted (Fig 2). The moderate cellular stroma was populated by slightly spindled cells having nuclei with coarse chromatin. Mitotic activity in both areas was sparse, and no more than one mitotic figure per 10 high power ($400\times$) fields was identified. The vascular spaces within the neoplasm were lined by unremarkable endothelial cells. There was an occasional eosinophil. The associated 5 cm uterine mass had histologic features consistent with a leiomyoma. The microscopic appearance of the tumor in the left ovary and metastatic nodules was identical to the uterine neoplasm.

Discussion

The morphology of this neoplasm is compatible with a uterine tumor resembling ovarian sex cord tumor (UTROSCT) first described by Clement and Scully in a report of 14 cases.² UTROSCT is a uterine tumor that contains morphologic patterns resembling sex-cord/stromal tumors of the ovary. They are usually seen in reproductive or postmenopausal patients who present with vaginal bleeding. Although the present patient had occasional postmenopausal bleeding, she sought medical attention and was evaluated only after development of deep venous thrombosis. The tumors range from 3 to 10 cm in size, are typically solid, and are well circumscribed. Histologically,

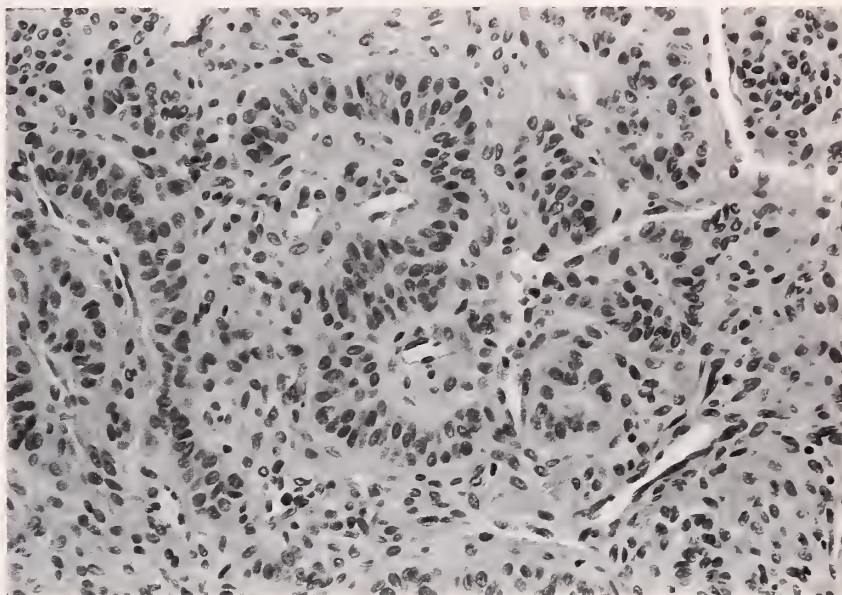


Fig 1 — Uterine tumor resembling ovarian sex cord tumor. Trabeculae of sex cord cells distinct from the stromal spindle cells are present (H & E $\times 200$).

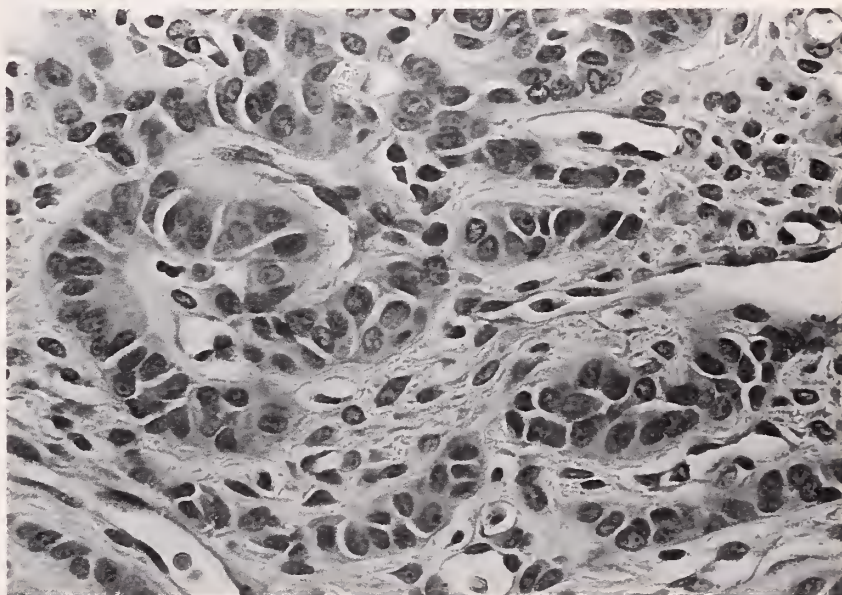


Fig 2 — Uterine tumor resembling ovarian sex cord tumor. The sex cord elements have abundant cytoplasm and prominent nucleoli yet lack the nuclear grooves of a granulosa cell tumor (H & E $\times 400$).

the tumor is also typically circumscribed, but may invade lymphatics and vascular spaces. The small, rounded epithelioid tumor cells arrange themselves into cords, tubules or trabeculae, and nest within a background of more typical stromal cells. In some cases, gland formation may be ap-

A Rare Uterine Tumor

parent resulting in a mistaken diagnosis of adenocarcinoma.^{2,3}

Originally, UTROSCTs were subcategorized into two groups depending on the predominant morphologic pattern present.¹ In Group I, the majority of cells are the stromal type; the epithelioid cells are only occasionally present. The Group II tumors are composed almost entirely of sex-cord type cells. In Group I patients with adequate follow up (ranging from 2 to 15 years), recurrences developed in three of five patients, and two patients died of disease. None of eight patients with predominant sex cord elements developed recurrences. Nevertheless, because of so few cases that have been reported, the overall behavior of this neoplasm is best considered unpredictable.² Prognostic features that may imply the tumor behavior in our patient are its infiltrative nature, the lymphovascular space involvement, the predominant stromal component (Group I pattern), and most importantly, the presence of metastases.

Treatment for patients with UTROSCTs has not been standardized. Since the index hospitalization, our patient has received six courses of Ifosfamide, Mesna and Adriamycin. At present, the pulmonary nodules have resolved but a vaginal nodule was found on interim pelvic examination. A biopsy of this vaginal lesion is consistent with the original diagnosis of UTROSCT. The predominant histology, however, was the stromal element.

In summary, this patient is an example of a uterine tumor atypically presenting with lower extremity thrombosis. Although it is easy to identify a uterine neoplasm in patients who present with a complaint of abnormal bleeding, the clinician must also consider this diagnosis in patients who present with obstructive pathology in the lower extremities.

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The Practicality of Using the SMAST and AUDIT to Screen for Alcoholism Among Adolescents in an Urban Private Family Practice

Alexandra I. Foster; Richard D. Blondell, MD; Stephen W. Looney, PhD

We assessed the practicality of using the Short Michigan Alcoholism Screening Test (SMAST) and the Alcohol Use Disorders Identification Test (AUDIT) in screening adolescents for alcoholism in a primary care setting. In addition, we sought to determine the prevalence of alcohol use among adolescents, 16-21 years of age, presenting to a private Family Medicine practice for medical care. A consecutive sample of 67 subjects presenting for medical care were asked to complete the SMAST and AUDIT questionnaires. Overall, 52 (78%) of the questionnaires were returned with complete data. Of the 52 patients, 25 (48%) admitted to drinking. Using a "positive" score on either the SMAST or AUDIT as a positive test for alcohol use yielded a sensitivity of 40% and a predictive value positive of 100%. Using a "negative" score on both the SMAST and AUDIT as a negative test for alcohol use yielded a specificity of 100% and a predictive value negative of 64%. Although alcohol use was relatively common considering the age group, using the SMAST and AUDIT to screen for alcoholism is labor intensive and is not practical in this situation. Because patients appeared to misinterpret some questions and were often accompanied to the office by their parents, their answers may not be valid. History of alcoholism taken upon typical office examination and relevant advice appears to be a better alternative to the use of questionnaires in determining the prevalence of alcohol use in this age group.

Many adult alcoholics began to abuse alcohol during adolescence. Alcohol abuse is often a contributing factor to the leading causes of death among adolescents: motor vehicle accidents, homicide, and suicide. Thus, pri-

mary care physicians may wish to identify alcohol problems among adolescents and take actions to prevent the negative consequences of alcohol abuse and the progression to overt alcoholism. The use of the Michigan Alcohol Screening Test (MAST)¹ or the Short Michigan Alcohol Screening Test (SMAST)² are recommended in standard primary care textbooks as screening tests for alcoholism.^{3,6} The Alcohol Use Disorders Identification Test (AUDIT) was developed recently by the World Health Organization as a screening test for alcohol misuse or dependence.⁷ Although the MAST and the AUDIT were validated for adults, there is some evidence that these tests may adequately identify alcohol problems among college students.^{8,9} There is also evidence that these tests are valid in primary care settings even though they were developed primarily as research tools.¹⁰ However, other authors have questioned the usefulness of these screening tests.^{11,12} This study was conducted to test the practicality of using the SMAST and the AUDIT in an urban private family medicine group practice to detect alcohol problems among adolescents.

Methods

This study was conducted in the private offices of a three-physician family medicine group practice between January and April of 1995. The subjects were drawn from a group of 67 consecutive patients, aged 16-21 years, who presented for medical care at the office. Each was given a packet which contained the SMAST and AUDIT questionnaires, a cover letter explaining the study, and questions concerning age and gender. The patients were told that their participation was voluntary. The participants completed the question-

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Using the SMAST and AUDIT to Screen for Alcoholism

naires anonymously and deposited them in a box before they left the office. The SMAST and AUDIT were scored in the standard manner as being either "positive" or "negative" for problem drinking. The questionnaires were also used to define a "non-drinker" group.

Results

Of the 67 questionnaires distributed, 53 (79%) were returned, but one participant did not complete one of the screening questionnaires and was excluded from the sample. Of the remaining 52, 12 (23%) were male, 31 (60%) were female, and 9 (17%) did not indicate their gender. Four participants did not indicate their age, but the average age of the remaining participants was 17.6 years, with fifteen 16-year olds (31%), twelve 17-year olds (25%), seven 18-year olds (15%), six 19-year olds (13%), and eight 20-year olds (17%). Thus, all patients in this study were under the legal age for purchasing alcoholic beverages.

Twenty-five (48%) of the 52 patients admitted to drinking. Of these 25, 3 (including one recovering alcoholic) had a "positive" score only on the SMAST, 5 had a "positive" score only on the AUDIT, and 2 had a "positive" score on both, yielding a total sensitivity of 40%. Of the 27 patients that did not admit to drinking, all had a "negative" score on both the SMAST and AUDIT, resulting in a specificity of 100%. Of the 10 patients that had a "positive" score on either the SMAST or AUDIT, all 10 admitted to drinking, yielding a predictive value positive of 100%. Of the 42 that had a "negative" score on both the SMAST and AUDIT, 27 did not admit to drinking, resulting in a predictive value negative of 64%.

Comments

Screening for alcohol problems in the private practice setting is labor intensive and time consuming. The process involves screening charts daily for participants in the proper age group, distributing questionnaires and tabulating results. We conclude that using the SMAST or the AUDIT is not practical in this setting.

The adolescents in this study may have misinterpreted the questions: there were inconsistencies in answers such as claiming to be non-drinkers but then answering that they drank on occasion. Furthermore, participants accompanied to the office by parents may have felt that they were unable to answer truthfully due to pa-

rental pressure against drinking alcohol. (On one occasion, a parent was observed filling out the questionnaire.)

We concluded that the information obtained on these questionnaires may not be valid. Researchers are trying to develop better questionnaires to identify adolescent problem drinkers.¹³ However, for primary care physicians, the goal may not be to identify adolescent problem drinkers, but to give a prevention message to all adolescents.

Although all of the individuals in this study group were under the legal age to purchase alcoholic beverages, almost half admitted to drinking on occasion. Not all of these adolescents were or would become alcoholics. Adolescents need not have a drinking problem per se to experience the negative consequences of abusive drinking (eg, motor vehicle accidents). Given the limited amount of time that primary care physicians have to spend with patients, it may be that the best use of the physician's time would be to ask one or two simple questions about alcohol use and deliver a prevention message.

A two-question screening test has been developed.¹⁴ The items are: "When was your last drink?" and, "Have you ever had a drinking problem?" These or similar questions could be asked of adolescents as part of a routine medical history, followed by an appropriate prevention message that reinforces what the adolescent hears at home, in school, and out in the community. This public health approach is generally considered the most effective way to reduce alcoholism.¹⁵

If the patient denies alcohol use the physician could reinforce that behavior with a positive statement such as "That shows a great deal of maturity. I know that there is a lot of peer pressure to drink, but you have taken a positive approach to your health by not drinking." Even adolescents who are not truthful about their alcohol use will still hear that positive message. These patients could also be cautioned not to ride in a car when the driver has been drinking.

If the patient admits to alcohol use, the physician could deliver a clear, unambiguous prevention message such as, "I know that it is hard to resist peer pressure to drink, but it would be better to find ways to have fun without drinking. It is important that you never drink and drive and you should not ride in a car when the driver has been drinking." Patients who also have a positive family history for alcoholism could be advised to learn more about alcoholism by attending an Alateen meeting.

If the patient admits to having had a problem with alcohol, the physician might inquire about this more. Some adolescents are recovering alcoholics and should be encouraged to keep going to their therapy groups or self-help groups, such as Alcoholics Anonymous. Other adolescents may need additional help from the primary care physician or through a referral for definitive therapy.

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Human Guinea Pigs Protecting Human Subjects

Richard L. Miller, DDS, PhD

IRB

We are fortunate to have a distinguished guest editorial which describes how we all treat our patients in our mundane practices: "Research involving humans must be explained to subjects in a manner where they understand the voluntary nature, risk/benefit, expenses, confidentiality of personal data and their rights as subjects."

Dr Richard L. Miller is the chair of the University Human Studies Committee, the Institutional Review Board (IRB) for the University of Louisville and Alliant Health System, Inc. — A. Evan Overstreet, MD, Editor

"Who are these IRB people and what are they doing with my research protocol? Why does it take so long to get IRB approval for such a straightforward project? Why must we change our informed consent when it was good enough for the other 40 research centers involved in this multi-center study? I have a morbid patient who needs immediate enrollment into a project that uses an investigational new drug and I don't have time to submit a protocol and 18 copies for IRB approval. This study had been approved for four years and now the fanatical nitpickers want us to change the informed consent. Those people over there (IRB) are crazy!"

All these comments, questions and more, represent the perceptions and opinions of some in the medical community of the role and functions

of an IRB. Such perceptions are not exclusive to this medical center or this community and reflect the frustrations of investigators who must seek IRB approval for clinical research or use of investigational drugs and devices in clinical therapy.

The use of humans as research testing subjects is in most instances considered superior to animal models or computer networks because data obtained best represents the parameters of human pathology, physiology and behavior. Blinded and placebo-based comparison data from human subjects is required for FDA approval of new drugs and devices. It is considered the best data to prove or disprove new therapies. The use of human subjects in research also affords us more subjective "quality of life" information that would be very difficult to obtain from other model systems. Usually objective data (adverse events, imaging, behavioral questionnaires) from human subjects are necessary to document the effects of therapeutic merit for drug or device approval, marketing, and distribution of valid information to the medical community. Finally, humans are frequently involved as research subjects because they are patients with therapeutic needs that their physicians feel can be best met with investigational drugs, devices, or procedures. The utilization and compassionate use of investigational drugs or devices for treatment of disease falls into the category of human research, even when data collections are not primary objectives.

The physician/investigator has profound interests both in the use of

human subjects for data collection and for patients who need such therapy. However, numerous and serious risks are present for "human guinea pigs" who submit to unapproved therapies and techniques that can threaten the subject's welfare. The use of the term "subject," rather than patient, attests to the risks and unproven nature of such research. The interests of society in developing knowledge to benefit individuals and society as a whole must be counterbalanced with the ethical protection of a human subject's welfare and privacy. The IRB provides a mechanism for this balancing act. Obvious abrogations of human rights (Nuremberg trial, Tuskegee syphilis study, early radiation studies) in research are well-known to the medical community and general public and have been highly publicized. Many more subtle and often well-intentioned problems exist or have the potential to exist on an everyday basis during the commission of medical research. As a long term investigator and IRB member, I can personally attest that respect for the ethical rights of human subjects in research has been markedly enhanced in the past several decades. These positive changes are primarily the result of our (investigators) increased definition of and awareness of ethical tenets and the regulations and enforcement promulgated on researchers by the IRB and federal oversight agencies (OPRR, FDA).

General guidelines for all research involving human subjects were agreed upon and disseminated in the Belmont Report of 1978. These

guidelines basically call for respect, beneficence, and justice for human subjects. Respect is anchored on dignity in patient involvement, autonomy of choice and special protection for vulnerable subjects or those of diminished capacity. Beneficence mandates that potential benefits of the research should outweigh risks involved. Research that is not scientifically sound has little benefit and is therefore not meritorious — no matter how minimal the risks. Justice is based on assurances that the benefits and burdens of research should be equally distributed on race, gender, social economic status and protected populations.

Sponsors and physicians demand expedited approval of protocols. Sponsors want data, investigators gain prestige and reward from completed projects, patients receive new treatments. IRBs must however afford careful and comprehensive review to help guarantee respect, beneficence and justice for subjects.

Most institutions contract with the Department of Health and Human Services (NIH) by means of a multiple project assurance document (MPA). This contract assures this federal agency that the institution has:

- a process for review of human studies (IRB)
- a faculty and administration sensitive to potential problems who are willing to protect human rights, and
- accepted and incorporated federal standards and guidelines into its approval and review mechanisms.

Compliance with this document is mandated with penalties (financial and criminal) for those in noncompliance. Both random and for-cause audits of investigators and IRBs by the NIH and the FDA can and do occur. The IRB thereby becomes an extension of the federal bureaucracy charged with approval and enforcement of the standards outlined in the MPA.

Institutional IRBs — as opposed to proprietary IRBs — are usually composed of volunteer faculty. Certain levels of expertise and representation (MDs, ethicist, lay person, psychologist, attorney) are both desirable and required in some instances. Members must provide both expertise in their field, understand the standards, consider the ethics of each situation, and interpret the MPA. Most new proposals, all continuing projects, amendments, and a plethora of adverse event reports must regularly be reviewed. This means there can be considerable activity for even a small medical center. Our IRB (University and Alliant) was responsible for 1600 annual reviews and 350 new reviews in 1996. Committee members, who are some of the busiest individuals in the University and in the hospitals, must find time for these additional voluntary activities. This mandates frequent and long regular meetings, special meetings, subcommittee activity (annual review, adverse events) and homework. Compliance and noncompliance issues are unusual but extremely time consuming.

The investigator is the individual who can best facilitate positive interaction with the IRB. Clear straightforward well written protocols are mandatory — we have spent days reviewing protocols, only to subsequently discover that the investigator has “copied” it from another institution and made no attempt to customize it to the local application. Scientific merit is seldom an issue; however, risk versus benefit research is occasionally problematic. By far, the bulk of issues pertains to informed consent. Research involving humans must be explained to subjects in a manner where they understand the voluntary nature, risk/benefit, expenses, confidentiality of personal data and their rights as subjects. Explanation must occur in a non-threatening, non-seductive

environment and explanations (informed consent) must be presented in a language (“laymanized”) the subject can understand. This allows for autonomy of choice. Since federal standards for informed consent are basically written in the law, they are almost always necessary inclusions in the informed consent document, and not very negotiable. Local standards are based on both federal guidelines and the local IRB experiences with noncompliance and subject complaint. Both federal and local standards for informed consent can and do change. Enforcement of these standards are often considered committee “nitpicking” when changes are requested and approval is delayed. Because committee composition and experience vary, standards frequently vary between institutions. Most IRBs will work out the variance of local standards with other institutional IRBs for multi-institutional projects when there is compliance with federal standards. Our University Human Studies Committee provides investigators with a current information guidelines packet and model informed consents. Additional forms for annual review, adverse events, and amendments are available on paper, disk or can be accessed electronically. Efficiency is best achieved by close adherence to these guidelines and models. Once again, potential delays can be avoided.

Most IRBs need expert members from the medical community. Volunteers are sought as regular committee members, alternates and consultants. Helping the IRB facilitates directly and indirectly the efficiency and quality of the approval process, and more importantly, the protection of human subjects. Some IRB members have even been thanked by investigators for their voluntary efforts.

The North American Medical Golf Association

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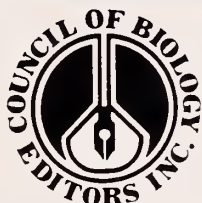
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Ruth Ryan

**WELCOME TO THE
ANNUAL CONVENTION of the
KENTUCKY MEDICAL ASSOCIATION ALLIANCE
APRIL 16-17, 1997**

Holiday Inn Hurstbourne at I-64, Louisville, Kentucky

This Convention not only marks many noted accomplishments of the past year, but is also a forum to develop new policies that address the issues impacting our spouses, our families, and our communities. All sessions are open to all physicians and physicians' spouses, but advance reservations are recommended. Please review the following agenda and mark your calendar to participate in any or all parts of this program that fit into your busy schedule. Your input is greatly appreciated!

WEDNESDAY, April 16, 1997:

At Holiday Inn Hurstbourne:

- * 9:00 am-5:00 pm: Registration & Hospitality
- * 11:00 am-2:00 pm: Working Luncheon/Combined Committees Meeting:
AMA-ERF, Health Promotion, Legislative Affairs,
Membership Development, Planning, Finance, Executive
- * 2:30-3:30 pm: Pre-Convention Board Meeting to act on proposed 1997-1998 budget

At the home of Dr and Mrs John Cowley, 1005 Alta Vista Road:

- * 6:30 pm: Reception for President-elect, Mrs Uday (Aroona) Dave,
followed by Dinner, Middle-Eastern Cuisine by Mr Ata;
Theme Basket Silent Auction to benefit McDowell House

THURSDAY, April 17, 1997

At Holiday Inn Hurstbourne:

- * 7:30-8:30 am: Registration & Hospitality
- * 8:30-11:30 am: House of Delegates Meeting

At Jacobson's in Oxmoor Mall:

- * 12:30-2:30 pm: Luncheon catered by Vincenzo's;
Style Show presented by Jacobson's;
Recognition of KMA Alliance Past Presidents & other
honored guests
Installation of Officers by AMA Alliance President, Mrs
John D. (Sandra) Mitchell
Adjournment

At Holiday Inn Hurstbourne:

- * 3:00 pm: Post-Convention Board Meeting

Complimentary round-trip transportation will be provided
between Holiday Inn and Dr and Mrs Cowley's home and
between Holiday Inn and Oxmoor Mall.

Ruth Ryan
KMAA President

Please be sure
to mark your
calendars and
to complete
and mail the
reservation forms
on the facing page!

To ensure the KMAA rate of \$79 for a double room, please make your room reservation directly with the Holiday Inn Hurstbourne by **March 28, 1997. Request Tower.**

HOLIDAY INN HURSTBOURNE ROOM RESERVATION FORM

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502/426-2600 FAX: 502/423-1605;

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By **April 10, 1997**, please send your Convention reservation form with a check payable to the Kentucky Medical Association Alliance to:

Mrs John Pank (Janet), 2407 Chatterworth Lane, Louisville, KY 40242-2851; 502/426-3612

CONVENTION RESERVATION FORM:

Name: _____

Address: _____

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Registration fee	\$10
Wednesday, 4/16/97 Working Luncheon: seven Committees _____	15
Wednesday, 4/16/97 Pre-Convention Board Meeting _____	0
Wednesday, 4/16/97 Reception/Dinner at home of Dr and Mrs John Cowley _____	20
Thursday, 4/17/97 Breakfast in Hospitality Room _____	0
Thursday, 4/17/97 House of Delegates Annual Meeting _____	0
Thursday, 4/17/97 Luncheon/Style Show at Jacobson's, Oxmoor _____	15
Thursday, 4/17/97 Post-Convention Board Meeting _____	0

Total \$ _____

All members are welcome to participate in any and all parts of this program!

If you have any questions, please contact KMAA Convention Chairmen:

Mrs David Bruenderman (Debbie), 326 Mockingbird Hill Road, Louisville, KY 40207-1814; 502/894-8832; or

Mrs John Cowley (Alice), 1005 Alta Vista Road, Louisville, KY 40205; 502/896-6049; or

KMAA President, Mrs John J. Ryan (Ruth), 1400 Willow #1606, Louisville, KY 40204-1467; 502/454-3302;

FAX: 502/454-5118.

NATIONAL HIV TELEPHONE CONSULTATION SERVICE FOR HEALTH CARE CLINICIANS

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The Warmline is staffed by physicians, clinical pharmacists, and other health care professionals expert in the clinical care of symptomatic and asymptomatic HIV disease.

WHEN TO CALL

Warmline faculty are available Monday through Friday, 7:30 am to 5 pm (Pacific Standard Time). Twenty-four hour voice messaging is available at other times.

Funded by the Health Resources and Services Administration, and the American Academy of Family Physicians.

Physical Therapy

I am sure that many doctors in the state have read or heard about a recent series of articles delineating abuses particularly of respiratory therapy which appeared in the *Lexington Herald Leader*.

As a rheumatologist, and with reference to physical therapy, I have found that on many occasions when I have written a prescription for a single visit or intended a single visit, I will get requests for authorizations (generally three to six months after my initial request was sent) wherein the therapist has been treating the patient two to three times a week for three to four months. This has usually occurred with *no* communication from the therapist to me.

This has led me to make a copy of the therapy prescription and enclose it in the chart so when I get these requests back I can go back and verify the instructions I had actually sent.

I am sure that there are many physicians who simply sign these forms, not realizing how many visits have been done nor realizing what the overall cost of the visits has been. Certainly there are instances in which a repeat visit is indicated for

reinstruction, or, for some problems, several therapeutic visits may be required. However, for most of the problems I deal with, a single instructional visit is all that is required.

I think it is incumbent upon the physicians to know in general terms what type of physical therapy is needed and for how long it should be prescribed. Certainly I do not tell the physical therapist what types of exercises to do. I generally will specify modality if one needs to be done such as ultrasound or deep heat, or if in certain cases multiple visits are needed, I will specify my thoughts on what is needed. In conjunction with this, I will let the physical therapist know I am available to discuss this with them if they feel more therapy is needed. In almost no instance has a physical therapist called me and said, "I think I need 'X' number of visits for this reason. Would you authorize it?" I don't think any physician would simply write on a prescription pad "Medicine for high blood pressure" and send it to the pharmacist and expect the pharmacist to select the drug, the dose, the route and the frequency of medication. Similarly I think we have to bear some responsibility as to how we

prescribe physical therapy and other therapeutic modalities.

Having observed a number of patients undergoing physical therapy, I have seen an extraordinary amount of physical therapy performed for which I think there is little basis justifying the number of visits scheduled. I do think this markedly increases the cost of the medical treatment.

I think, as with everything else, if one is going to prescribe physical therapy, one must take responsibility to understand how often and how long such therapy should be done. I realize all of us are busy and it is an inconvenience to have to stop what you are doing and talk to a physical therapist. I think, however, in this era we must look at doing appropriate amounts of therapy whether physical therapy, occupational therapy, respiratory therapy, or drug therapy and we must try to prescribe the appropriate amount and type of therapy for our patients.

Recently passed fraud and abuse legislation may or may not also affect the way you prescribe ancillary services.

Paul M. Goldfarb, MD

Kentucky Workers Compensation

I particularly enjoyed the article regarding Kentucky Workers Compensation in the November issue. This is certainly one of the most concise and best written expositions on any problem that I have ever read.

I am concerned however that physicians always seem to be "circling the wagons" to adopt some kind of defensive posture. I think physicians are being taken advantage

of and are being held as scape goats in much of the present discussion.

For instance, as regards the issue of "non-graphic soft tissue injuries" referred to in the article, physicians need to agitate evermore strongly for tort reform. Our only chance of reducing costs on these "non-graphic" types of injuries is to press our claim forcefully that it is precisely our present tort system and excessive regulation which run up the medical costs in the evaluation of these types of injuries.

Additionally, I am concerned that

"medical" institutions do not necessarily have the same interests as physicians in this whole situation. Hospitals, in some cases of which I am personally aware, seem just as eager as plaintiff's attorneys to run up huge medical bills and Emergency Room bills on these patients. I think as physicians if we are to survive with any kind of professional independence we must team up with the workers and employers who are buying this insurance to control these costs even if it means facing off in some kind of collective way with such

institutions. I think it is very important for physicians to constantly evaluate their own efforts on behalf of patients for effectiveness. We must be honest about the quality and effectiveness of our own efforts and likewise we must seek to identify where our efforts are constrained by the system, for instance by plaintiffs' attorneys who play on patients' anxieties so that it is impossible for any treatment to be effective.

Governor Patton has made a good point that some workers have treated the workers comp system as a type of retirement program. Physicians have been caught in the middle of this and I don't believe it is to the credit of our profession, though it may be something that we are powerless to deal with.

Finally, I think we should not be afraid to put forward radical solutions, for instance coverage of "non-graphic soft tissue injuries," on the basis of a different kind of insurance than that of coverage for "graphic injuries." For instance, one scenario would be for workers to purchase their own insurance for non-graphic types of injuries if they desire to do so. This would be an important precedent for physicians since it would be a first step towards a system where patients would assume responsibility for "negative treatment outcomes" as a result of medical treatment in general as opposed to having physicians purchase insurance for medical negligence, as is the case now.

The reason I make such radical proposals is I believe that there are

two threats here: 1) That physicians will come to be seen as having no input into the structure of the system and be reduced to a role where we will no longer have influence on the course of care of the patient; 2) That certain industries such as the coal industry will become so crippled by high comp rates that a wholesale shut down will result. Additionally, I am very interested in your figure four of the article. I think that given that our trial judges have been inflating physicians disability ratings by two thirds, the physicians should consider this when assigning disability ratings in the first place.

F. Andrew Morfesis, MD

Letters to the Editor

The Editorial Board of the *Journal of the Kentucky Medical Association* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to:

Editor
Journal of the Kentucky Medical Association
 The KMA Building
 4965 US Hwy 42, Suite 2000
 Louisville, KY 40222-6301

PEOPLE

Bogdan Nedelkoff, MD, a Louisville pathologist, recently celebrated his 35th anniversary with the University of Louisville School of Medicine Department of Pathology.

UPDATES

Medicaid Reimbursement

As a result of a lawsuit brought by the Kentucky Medical Association, Kentucky physicians are currently receiving an increase of \$26 million in Medicaid reimbursement for fiscal years July 1, 1996-June 30, 1997, and July 1, 1997-June 30, 1998. This increase became effective for paid claims with dates of service on or after July 1, 1996.

Physicians are also receiving \$52 million in reimbursement for Kentucky Medicaid claims made by providers during the July 1, 1995-June 30, 1996 time period. In November, 1996, the Department for Medicaid Services sent a letter to each Medicaid provider setting forth the amount of money representing claims made by the provider for the dates of July 1, 1995-June 30, 1996. Each provider was to receive approximately 26% of the amount stated in the letter. If a physician or provider disputed the amount, the Department for Medicaid Services gave the provider until December 31, 1996, to appeal.

According to the Department for Medicaid Services, the appeals by providers have been processed and checks were mailed to providers on January 30, 1997. These payments represent the \$52 million

reimbursement to physicians which was a direct result of the lawsuit brought by the KMA.

Many providers have contacted the KMA to say that they have received their reimbursement checks from the Department for Medicaid Services. One question that continually arises, however, is whether the reimbursement check is subject to the Kentucky Provider Tax. The Kentucky Provider Tax places a tax on the "gross revenues" of providers. Under Kentucky law, "gross revenue" is defined as "the total amount received in money or otherwise by a provider for the provision of health care items or services in Kentucky. . . ." On the face of the definition of "gross revenues" it appears that the money received by providers as a result of the lawsuit may be subject to the Provider Tax, but, physicians are encouraged to discuss the issue with their CPA or attorney to see whether this money is, in fact, taxable.

Medicaid/Board of Trustees Action

KMA officers met with Governor Paul Patton and Lt Governor **Stephen Henry, MD**, in January to discuss the KMA Board of Trustees' concern with the Medicaid administration's proposal to implement the provision of services through Regional Managed Care Partnerships (1115 Waiver). On December 23, KMA's concerns were voiced in a public hearing in

Frankfort. **William H. Mitchell, MD**, KMA president, noted the following in a letter to Governor Patton:

KMA recognizes the Cabinet's exploration of different ways to administer the Kentucky Medicaid program. KMA's primary concern is that patient care not be adversely affected by a new methodology. Inherent in current proposals to privatize Medicaid are increased administrative and overhead costs, a consideration of return on investment, and the creation of a new bureaucracy. Because of these and other concerns, KMA suggests that the Cabinet limit implementation of privatization methodologies to one, or perhaps two, pilot projects.

Based upon activities to date, it appears such a pilot project would be centered in either Region 3 or 5, or both. The Association further suggests that while other areas of the state may wish to develop an infrastructure capable of supporting a managed care partnership, actual implementation of this strategy should be held in abeyance until the pilot projects clearly demonstrate their value to the Commonwealth.

As the pilot programs attempt to demonstrate their effectiveness, we suggest that the current KenPAC program be enhanced; additional Medicaid recipients could be placed under KenPAC and this program could be used as a reference point for comparison with efficiencies sought in the pilot programs. Currently, there is very little utilization review in KenPAC and as a first step we suggest enhancement of utilization management efforts. This might improve KenPAC to a level that privatization becomes unnecessary.

In summary, Kentucky Medical Association is suggesting a moratorium on privatization projects until the pilot project or projects alluded to earlier demonstrate positive results. KMA believes proposed regulations should be modified accordingly.

Impaired Physicians Program

9000 Wessex Place, Suite 305
Louisville, KY 40222

Phone 502/425-7761; Fax 502/425-6871

New HCFA HMO Policies

The Health Care Financing Administration (HCFA) recently announced new rules governing the contractual relationships between HMOs and physicians. HCFA banned so-called "gag clauses" in the treatment of Medicare beneficiaries and announced new rules regulating the awarding of bonuses and paying physicians from withholds in certain payment arrangements. HMOs are also required to purchase "stop-loss" insurance and must disclose physician incentive plans to HCFA.

KMA Practice Management Workshops Drawing Large Attendance from State

More than 150 physicians, office managers and billing personnel attended one of the three workshops held January 28-30 in Pikeville, Lexington and Louisville. The "Audit-Proof Your Practice" Seminar, presented by Conomikes Associates, was cosponsored by the KMA and the Pike, Fayette and Jefferson county medical societies. The day-long session featured an overview of the new laws and regulations dealing with fraud and what constitutes "red flags" in claims filing and documentation.

In February, the "How to Run a More Profitable Practice" workshops, February 25-26, in Lexington and Louisville, both had full registrations with a total of 100 physicians and office managers attending. The annual "Getting Started in Medical Practice" Seminar, now in its 15th year, was held at the KMA Office in Louisville and was attended by a capacity number of residents and spouses.

"Coding and Reimbursement" will be the topic for the March 19-20 seminars scheduled in Lexington and Louisville and additional arrangements are being made for further coding sessions later in the

year in other parts of the state due to the popularity of this particular workshop.

For further information on these and other workshops, please contact the Membership Department at KMA, 502/426-6200.

Are You Relocating to a Critical Area in Kentucky and Have Educational Debt???

The Rural Kentucky Medical Scholarship Fund, Inc offers an additional program to continue to address the problem of maldistribution of physicians – the Establish Practice Grant Program (EPGP). This program enables primary care physicians who are beginning a practice in a critical area of Kentucky and have educational debt to get some assistance in repayment.

The EPGP offers \$10,000 per year to a licensed full-time physician who has practiced in a critical county of Kentucky as designated by the RKMSF for four years, or up to \$40,000. The EPGP is limited to five participants per year. The program currently has four vacancies for 1997.

If you are interested in additional information and an application, please contact the Rural Kentucky Medical Scholarship Fund, Inc/EPGP office at 502.426.6200, or 4965 US Hwy 42, Suite 2000, Louisville, KY 40222.

KMA Members Benefit from Workers' Compensation Group Plan

Over 120 KMA member physician offices have received a 15% return on Workers' Compensation insurance premiums paid during the past year.

Individual dividends were based on claim experience of the group, the number of employees and length of time enrolled. The total amount returned for the KMA group was almost \$23,000.

A member benefit program since 1985, the Plan is administered by Casualty Reciprocal Exchange, a member of the Dodson Group. For further information about the Plan, contact Dodson toll-free at 1-800/825-9489.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Milton M. Slocum, MD —S
PO Box 694, Glasgow 42142-0694
1988, Louisiana, New Orleans

Boyd

Bob M. Crider, DMD —DENT
2000 Carter Ave, Ashland 41101
1966, U of Louisville

Winfield Clinton John, III, DMD —DENT
2301 Lexington Ave, Ste 120, Ashland 41101
1974, U of Kentucky

Alexander T. Krivchenia, II, MD —EM
20925 State Route 3, Rush 41168
1981, Case Western Reserve

Lisa W. McCoy, MD —FP
PO Box 1633, Ashland 41105
1993, U of Kentucky

Sriharsha Velury, MD —C
1003 Lynn Ct, Russell 41169
1982, Gandhi, India

Calloway

Jerry L. Edwards, DO —EM
505 Main St, Murray 42071
1982, West Virginia, Lewisburg

Christian

Ramesh V. Patel, MD —ONC
1717 High St, Ste 1A, Hopkinsville 42240
1979, M.P. Shah, India

Clark

Shanda L. Morris, MD —FP
1120 McCann Dr, Winchester 40391-1157
1993, U of Kentucky

Clinton

David C. Chaffin, MD —R
PO Box 415, Albany 42602-0415
1972, U of Tennessee

Daviess

Brent O. Bergen, MD —PUD
PO Box 1875, Owensboro 42302
1990, U of Oklahoma

Fulton

Ronald J. Cavanagh, MD —P
405 Park Ave, Fulton 42041-1378
1965, New York Medical College

Henderson

Warren A. Rader, MD —FP
976 Millcreek Dr, Henderson 42420
1977, U of Guadalajara

J. Criss Yelton, MD —ORS
471 Klutey Park Plaza Dr, Henderson 42420-3347
1983, Bowman Gray

Hopkins

Joseph P. Coladonato, MD —NS
200 Clinic Dr, Madisonville 42431
1972, Hahnemann

Hanna B. Konarzewska, MD —IM
200 Clinic Dr, Madisonville 42431
1982, Warsaw, Poland

Alfredo Nova, MD —OBG
200 Clinic Dr, Madisonville 42431
1984, Catholic U of Sacred Heart, Italy

Jeffrey K. Riggs, DO —GE
1217 Bark Ridge Cir, Hopkinsville 42240
1991, Southeastern

Nanda M. Shah, MD —OBG
1297 Morris Ln, Hopkinsville 42240
1977, Government Med Col, India

Alaa El-Din Soltan, MD —IM
200 Clinic Dr, Madisonville 42431
1985, U of Mansurra, Egypt

Hardin

Christopher G. Knight, MD —OPH
1109 Woodland Dr, Elizabethtown 42701
1971, U of Louisville

Jefferson

Klaus-Michael Boel, MD —PD
PO Box 379, Prospect 40059
1993, U of Louisville

Philip O. Dripchak, MD —ORS
1900 Bluegrass Ave, Louisville 40215
1986, CMDNJ, Newark

Darin A. Harden, MD —N
17118 Mallat Hill Dr, Louisville 40245-4475
1992, U of Kentucky

Jeffrey B. Hargis, MD —HEM
250 E Liberty St, Ste 802, Louisville 40202
1984, U of Cincinnati

Kristine E. McCorquodale, MD —PD
917 Rosemary Dr, Louisville 40213
1993, U of South Carolina

Jonathan D. Nussdorf, MD —OPH
100 E Liberty St, Ste 800, Louisville 40202
1991, U of Louisville

John P. Oliphant, MD —PD
1802 Ballard Mill Ln, Louisville 40207
1993, U of Louisville

Evelyn O. Overbey, MD —AN
1820 Sherwood Ave, Apt 31, Louisville 40205
1992, U of Louisville

Leslie A. Schuschke, MD —PD
9121 Crawley Ct, Apt 6, Louisville 40241-3261
1990, U of Louisville

Madison

Ralph D. Marionneaux, MD —FP
793 Eastern Byp, Ste 214, Richmond
40475
1991, U of Kentucky

Mason

Richard S. Hartman, MD —R
502 Lakeview Glen Dr, Maysville
41056
1990, U of Kentucky

McCracken

Monte E. Rommelman, MD —PMR
225 Medical Center Dr, Ste 401,
Paducah 42002-7843
1991, U of Louisville

Pike

Philip L. Casingal, MD —AN
Bowles Park Dr, Apt A3 Upper,
Pikeville 41501

1992, Marshall
Jay V. Narola, MD —P
128 Cedar Creek Rd, Pikeville 41501
1982, Government Med Col, India

Jesus R. Rangel, MD —PD
PO Box 2708, Pikeville 41502
1968, Central U of Caracas, Venezuela

Pulaski

Scott A. Dempewolf, MD —OTO
402 Bogle St, Ste 3, Somerset 42503
1991, U of Oklahoma

Cyril G. Kohrman, MD —U
311 Langdon St, Somerset 42503-2750
1991, Wright State U

Simpson

Randall P. Davidson, MD —FP
122 Memorial Dr, Franklin 42134
1993, U of Kentucky

Whitley

George A. Liu, MD —S
2 Trillium Way, Ste 302, Corbin 40701
1988, Meharry Med Col

In-Training**Fayette**

J. Lynn Jefferies, MD —IM

Jefferson

Katherine A. Abbott, MD —PD
Margaret A. Altman, MD —IM
Ty W. Carter, MD —ORS

Jennifer Evans, MD —OBG
Rene Ellen Fitzpatrick, MD —OBG

Steven T. Hester, MD —IM

Kelly Wickline Morgan, MD —IM

John David Rosdeutscher, MD

—OTO

Brad L. Sandleback, MD —EM

DEATHS

Gaston N. Maya, MD
Louisville
1920-1996

Gaston N. Maya, MD, a retired family physician, died December 11, 1996. A 1947 graduate of the University of Havana School of Medicine, Dr Maya was a life member of KMA.

George B. Boeckmann, MD
Horse Cave
1938-1996

George B. Boeckmann, MD, a family physician, died December 11, 1996. Dr Boeckmann was a 1968 graduate of the University of Louisville School of Medicine and an active member of KMA.

William W. Spalding, MD
Louisville
1927-1996

William W. Spalding, MD, a retired family physician, died December 19, 1996. Dr Spalding was a 1954 graduate of the University of Louisville School of Medicine and a life member of KMA.

Thelma S. Manlavi, MD
Hopkinsville
1930-1997

Thelma S. Manlavi, MD, a psychiatrist,

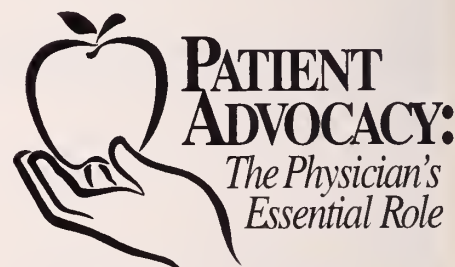
died January 1, 1997. A 1955 graduate of the University of Santo Tomas, Phillippines, Dr Manlavi was an active member of KMA.

Carolyn D. Blair, MD
Louisville
1962-1997

Carolyn D. Blair, MD, an internist, died January 1, 1997. Dr Blair was a 1986 graduate of the University of Louisville School of Medicine and an active member of KMA.

Patrick A. O'Neill, MD
Owensboro
1921-1997

Patrick A. O'Neill, MD, a general practitioner, died January 8, 1997. Dr O'Neill was a 1955 graduate of the University of Louisville School of Medicine and an active member of KMA.

Mark Your Calendar!

*KMA Annual Meeting • Sept 15-17 • Hyatt Regency
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RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates: \$40 per insertion (\$20 for KMA members) for the first 30 words; 50¢ for each additional word.

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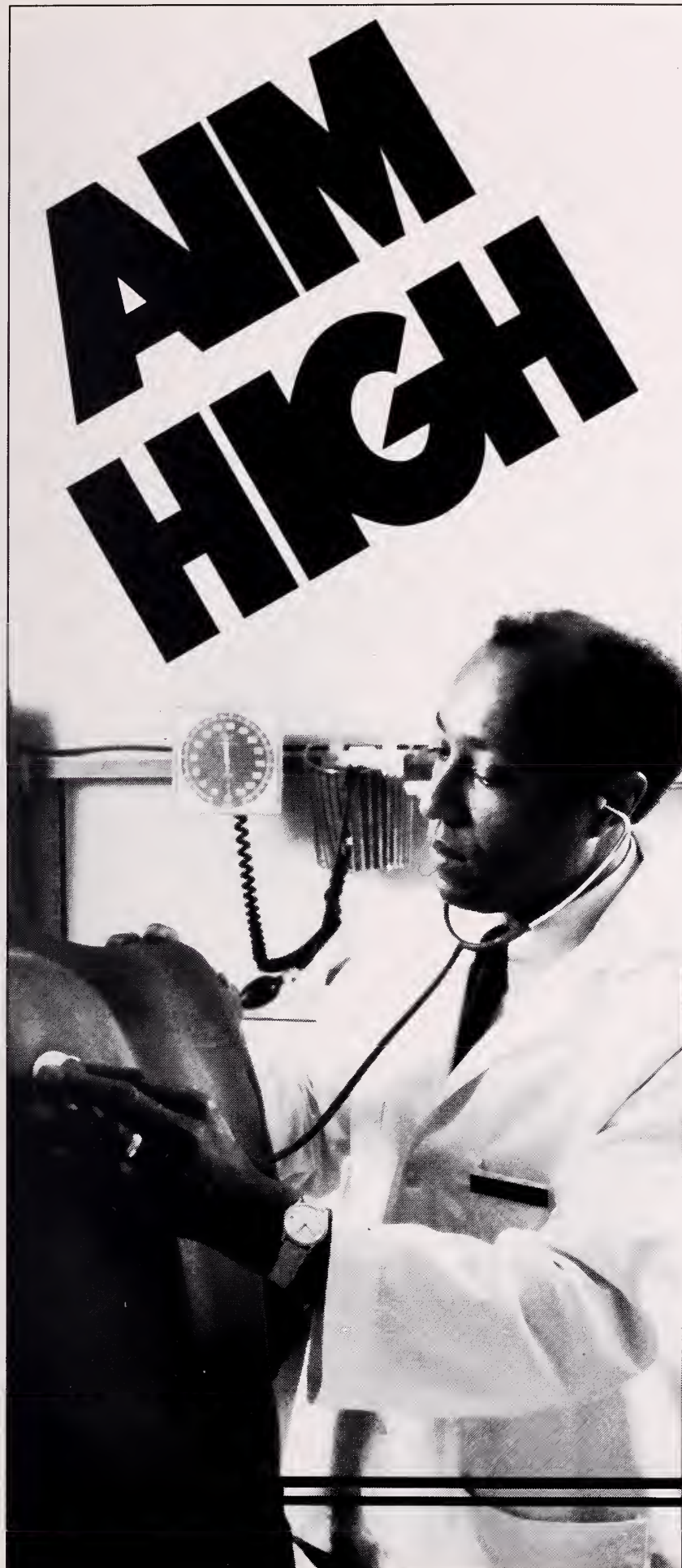
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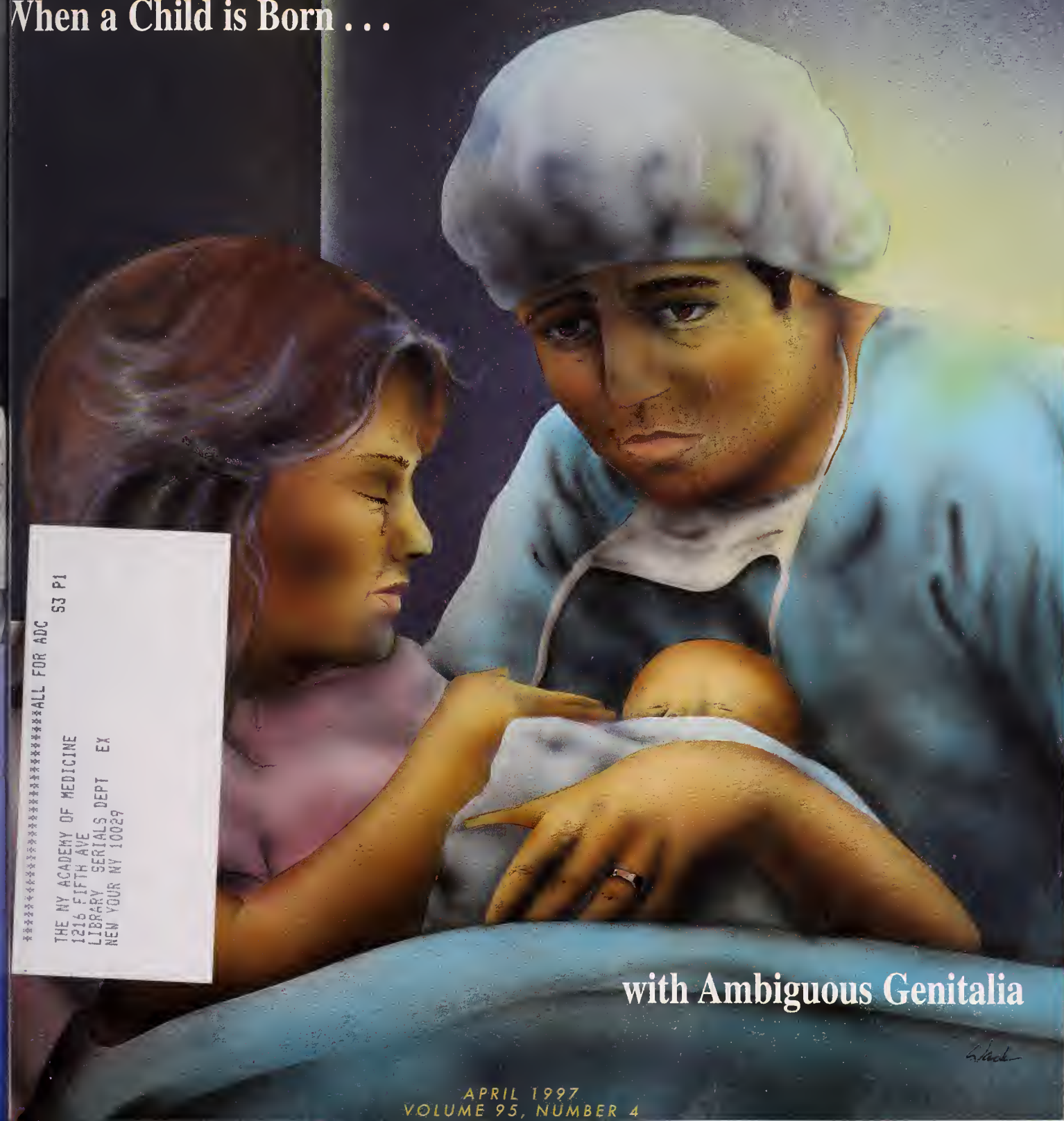
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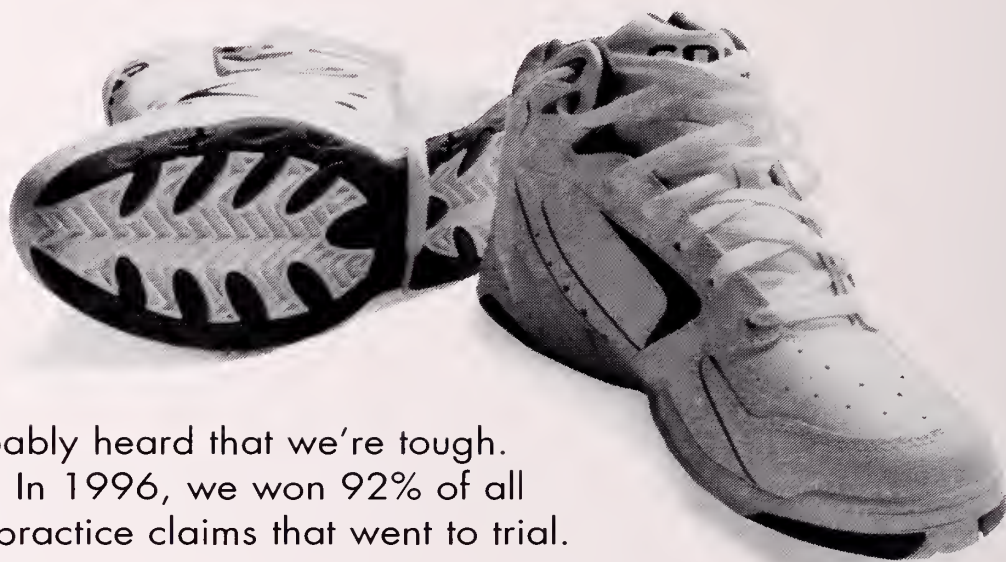


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COVER STORY	Diagnostic Evaluation and Management of the Child With Ambiguous Genitalia (Grand Rounds) <i>Bruce L. Slaughenhaupt, MD</i>	135
SCIENTIFIC	Retroperitoneal Repair of an Abdominal Aortic Aneurysm Associated With a Horseshoe Kidney <i>R. Adoumie, MD; J. Hamman, MD</i>	143
SPECIAL ARTICLES	Tornado Disasters and Stress Responses <i>Linda S. Godleski, MD</i>	145
	Breaking the Cycle of Domestic Violence: The Physician's Role <i>Baretta R. Casey, MD</i>	150
EDITORIAL	The Shoe on the Other Foot <i>Jaroslav P. Stulc, MD</i>	157
ASSOCIATION	Monitoring Medicine News KMA Practice Management Seminars Donald R. Stephens, MD, Nominated KMA President-Elect	131 163 165 167
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Classified Information for Authors Letters to the Editor	129 170 161 169 141 155



COVER: A Louisville urologist clarifies the complex topic of ambiguous genitalia and describes its various causes. Artwork by Lee Wade of Eminence, Kentucky. (With permission to reprint from Dr Slaughenhaupt.)

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What is a "Willing Provider?"



William H. Mitchell, MD

The Kentucky Medical Association has established policy that addresses the concept of "Any Willing Provider" as a basic principal to be defended. The coming year will see major challenges to our profession. One of the challenges we will see will be to the concept of "Any Willing Provider." I will say, for the record, that I believe it is in the fundamental best interest of our profession that we should oppose any effort to overturn the principal of "any willing provider."

Having said that, I believe that the challenge will come not from the Government, not from insurance companies, and not from Managed Care Organizations. The challenge will come from within our own house; it will come from the very people that the principal was designed to protect. It will come from physicians' groups.

The "Giant Killer Argument" against "Any Willing Provider" is to be found in the "All-Star Team Analogy."

Let's apply the reasoning behind "Any Willing Provider" to athletic contests. Suppose that at the end of an athletic season there will be an All-Star Game. Two coaches are chosen and the rules are laid out.

"In my opinion, the any willing provider provision is a protection on the front end to ensure that all physicians have a fair chance to offer their services for patient care. The details of that participation should be spelled out in the contractual agreement."

One coach is allowed to hold tryouts, interview players to assess attitudes, and hold practices to sound the depths of specific abilities. This coach is permitted to have a game plan to play the best players in their strongest positions. This coach is allowed to reward the best and punish the worst and has complete latitude to correct abhorrent behavior.

The other coach is required to accept any league player regardless of ability, performance, or behavior. Any players who wish to be on the team

may participate, play as long as they wish, and have no burden of consequence with regard to their degree of contribution.

Suppose further, that two coaches are found who will accept the latter parameters. The game is played and who do you believe will be successful?

If this type of arrangement were to be put into practice in an athletic contest, the cry about unfairness would be deafening. No one would accept this as an equitable way to frame a competition.

This sounds simplistic and it is. Obviously, there are more factors that come into play. The concept perhaps should not be "Any Willing Provider" but "Any Willing Applicant." Any qualified, credentialed, and competent provider of medical services should be permitted without obstruction to apply for participation in any managed care activity. If the applicant meets the credentialing criteria and is willing to abide by the contractual agreement set out by the managed care arrangement, then that person should be allowed to participate.

This does not mean that utilization and quality guidelines do

not need to be met. It seems fair for the contracting entity to set a reasonable standard for utilization and quality. That standard should be applied equally and equitably to all providers. Those individuals who are either incapable or unwilling to meet that standard might be fairly excluded from the arrangement.

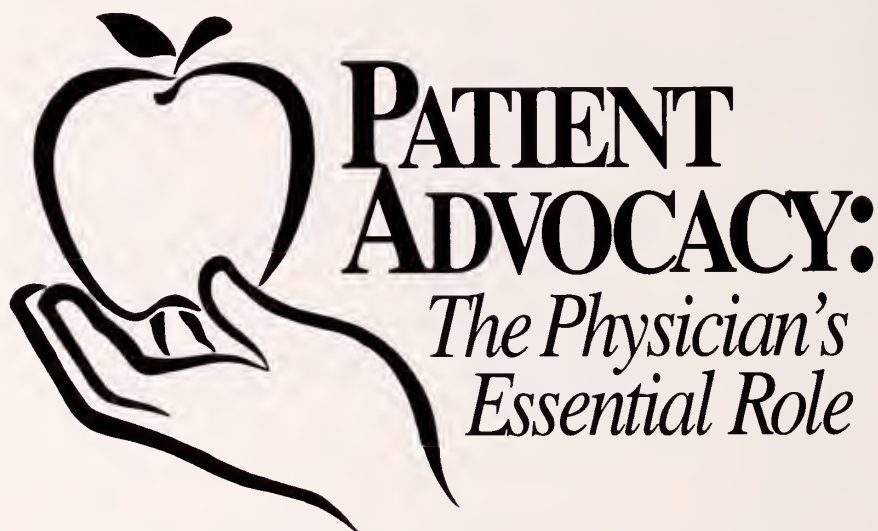
The protection that physicians enjoy in a managed care arrangement should be spelled out in the contract that we sign to participate. In my opinion, the any willing provider provision is a protection on the front

end to ensure that all physicians have a fair chance to offer their services for patient care. The details of that participation should be spelled out in the contractual agreement. We need to increase our vigilance, and focus our attention on the individual contracts of managed care companies. We need to be sure that not only utilization and quality standards are met by the contract, but also we need to ensure that ethical standards are maintained in these contracts.

As we face the changes in this

era of managed care, we should support the concept of "any willing provider" as the concept of "any willing applicant." Beyond that, we need to have active surveillance of the managed care contracts to be sure that the provisions of the contract are ethical and do not permit arbitrary and capricious exclusion of physicians from managed care arrangements.

William H. Mitchell, MD
KMA President



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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

AMA Action National Legislation —Gag Clauses

On February 5, legislation was introduced in the House of Representatives which would eliminate "gag clauses" in all health care plans. This legislation, HR 586, the "Patient Right to Know Act of 1997," was introduced by Representatives Greg Ganske (R-IA) and Ed Markey (D-MA).

The KMA applauds the sponsors for introducing this important and timely legislation at the beginning of the 105th Congress. We believe that establishing a federal standard to protect medical communications between patients and their physicians will return to patients the ability to make informed decisions regarding their health care needs. Although voluntary efforts to overcome "gag clauses" offer the appearance of reform, the AMA believes that this legislation is significant because it will put in place the force of law to address this serious public problem.

Over a year ago the AMA called upon managed care plans to immediately cancel gag clauses in their contracts with physicians. To their credit, some health plans have done just that. Unfortunately, not all health plans have acted as responsibly. The AMA believes that health plans that voluntarily remove "gag clauses" and eliminate "gag practices" should be commended. We know, however, that without federal legislation, many patients receiving care from those plans that do not — or will not — make changes are placed in peril every day. To this end, we are pleased that the "Patient Right to Know Act of 1997" will protect patients by eliminating both "gag clauses" and "gag practices" in all health care plans.

The AMA will work with Congress and the Administration to ensure that patients receive all the information they need to make informed

decisions about their health care. While physicians have a legal and ethical duty to provide patients with all the information they require, we believe that patients should no longer fear that third-party payors could potentially interfere with a patient's ability to receive crucial medical information.

Enactment of this legislation is a high priority for the AMA/KMA and we are pursuing as many cosponsors as possible in order to heighten the likelihood of the bill's passage. KMA urges all physicians to contact their Congressmen and ask that they co-sponsor HR 586. Congressman Ed Whitfield is the only Kentucky Congressman sponsor as of March 14, 1997.

The Kentucky Medical Association strongly supports health care liability reforms including a \$250,000 cap on non-economic damages.

Effective health care liability reforms should be based on California's proven Medical Injury Compensation Reform Act (MICRA) and include a \$250,000 cap on non-economic awards. In 1995 the Congressional Budget Office (CBO) found that liability reform, including a \$250,000 cap on non-economic damages, would significantly reduce projected increases in Medicare spending.

Recent data shows that health care liability costs are increasing much faster than medical inflation or other tort costs. Medical liability insurance costs have increased by 48.6% since 1990, according to a 1996 Tillinghast actuarial firm report. In contrast, tort costs overall appear to have stabilized. This report confirms that medical liability is the part of the tort system most in need of reform.

Kentucky Senior Senator Wendell H. Ford is a member of the Senate Commerce



Committee which is scheduled to take up this bill. His support is crucial to passage of this amendment.

Every member is encouraged to

contact Senator Ford and seek his support for medical liability reform and enactment of a \$250,000 cap on non-economic damages; it is critically important, however, that

these reforms be included in the committee mark-up of S.5, the Products Liability Reform bill.

State Legislative Activities

Physician/Nurse Collaborative Agreements

On February 20 the Kentucky Board of Medical Licensure held a hearing on Physician/Advanced Registered Nurse Practitioner collaborative agreements. The Board of Medical Licensure is considering drafting regulations relating to joint practices. In addition, the Kentucky Board of Nursing is also in the process of considering similar regulations. The Kentucky Medical Association has submitted the

following comments/suggestions for consideration by the respective Boards.

- Require Board approval prior to entering collaborative agreements
- Formal reporting mechanisms established between respective Boards
- Termination of agreements triggered automatically when disciplinary action taken against the practitioner
- Practitioner should be fully aware

of the other collaborative partner's standards and areas of practice

- Limitations on the number of ARNPs which a single physician may collaborate
- Agreements should be limited to practices in which parties have demonstrated competence and hold appropriate credentials
- Both parties should hold Kentucky licenses

Prescriptive Drug Abuse

On January 14 the KMA leadership held a meeting with Governor Paul Patton and Lt Governor Steve Henry, MD, to discuss Medicaid managed care partnerships. Governor Patton urged KMA to work with the Administration to curb provider prescriptive drug abuse. The Governor declared his intent to address this problem through legislation if necessary. KMA pledged its support to the Governor and shared his concern with any

illegal activity by anyone including physicians. Following that meeting KMA scheduled a Quick Action Committee meeting with the Secretary and Commissioner Rice Leach, MD. At the Quick Action Committee on January 23, Doctor Leach presented ideas which were later embodied in a formal presentation to the KMA Committee on Community and Rural Health. In addition to the Governor's interest in this area, Attorney General Ben Chandler has formed a task force to

look into prescriptive abuse. Chandler's task force is predominantly composed of law enforcement officials. The Quick Action Committee named William E. Doll, Jr, KMA's legislative legal counsel, to this task force. The Task Force appears to be oriented strictly to either strongly enforcing the law or changing the statutes to make it easier for law enforcement authorities to intervene.

Optometrist Hospital Staff Privileges

The Kentucky Optometry Association is lobbying for an amendment to regulations that would specify optometrists as members of a hospital medical staff. The Cabinet for Health Services was in the process of drafting regulations to implement legislation adopted by the 1996 Kentucky General Assembly that permitted optometrists to prescribe narcotics. That particular legislation did not deal in any manner with hospital privileges.

The proposed amendment makes a significant change in the regulation by appearing to require hospitals to have optometrists on staffs. This goes far beyond the intent of the 1996 legislation. Optometrists contend that a change is needed to ensure that optometrists "may" have hospital privileges. Optometrists "may" have such privileges now, but that is determined on a case by case basis by each hospital. Optometrists,

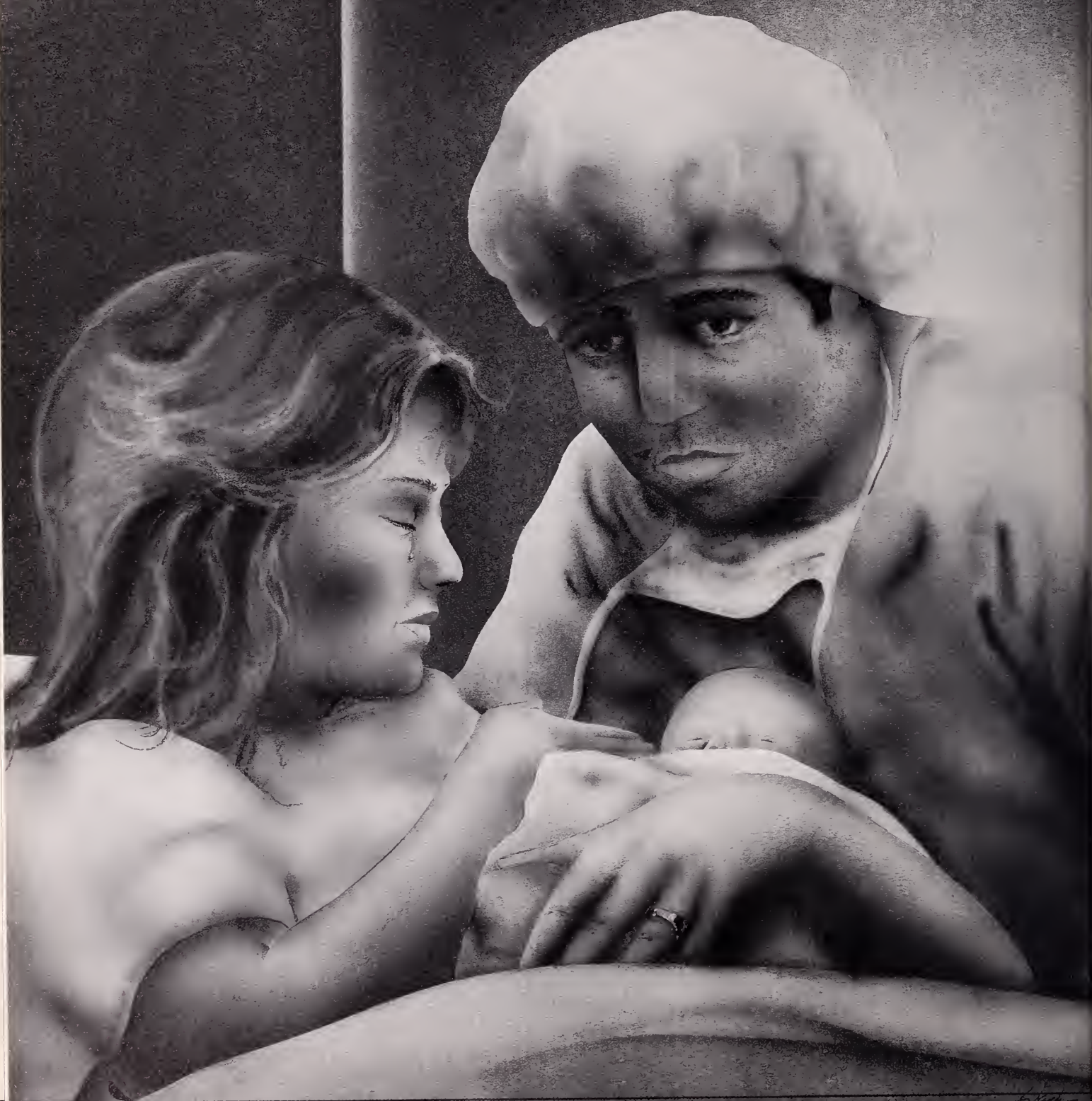
while "doctors," are not physicians. The training and experience required is not the same as a physician. Requiring hospitals to grant optometrists medical staff privileges would not improve the quality of care to patients, which is the primary concern in such matters. **CONTACT YOUR STATE LEGISLATOR TO OPPOSE THIS ONEROUS PROPOSAL.**

Medicaid Managed Care Regulations

A public hearing regarding the implementation of the Medicaid Managed Care plan was held in late December. KMA presented comments on proposed regulations that would govern the Partnerships in the Medicaid Managed Care Plan. Many aspects of the proposed regulations were troubling, including the fact that there was no mention of Kentucky's Any Willing Provider

law; "gag clauses" had not been banned; "traditional Medicaid providers" was defined in such a way that few physicians could have participated in the program; and there was no language that would allow a physician to transfer a Medicaid recipient to another physician. All of these points were made at the hearing and were subsequently changed to conform to KMA's desires. In addition, the

Cabinet for Health Services has agreed to changes in the regulations and delayed "bidding out" the Medicaid contracts to non-provider entities until the year 2000. KMA leadership has met with the Governor, Lt Governor, Secretary of the Cabinet, and Secretary of Health Services on two occasions outlining KMA's position on the proposed partnerships.



Diagnostic Evaluation and Management of the Child With Ambiguous Genitalia

Bruce L. Slaughenhaupt, MD

When it is first noted in the newborn nursery that a child is born with ambiguous genitalia, it can be very upsetting and confusing for parents, as well as challenging for pediatricians and nursing staff. In this article, I hope to clarify the rather complex topic of ambiguous genitalia and its various causes. I will also review normal genital development, as well as the medical and surgical management of the various forms of ambiguous genitalia.

Under normal circumstances, boys are born with a straight penis that has a circumferential prepuce. In 97% of full-term infant boys, both testes are descended into a fusiform scrotum.¹ This phenotypic composite of a straight phallus and two descended testes comprises the normal definition of male genitalia. Most girls are born with a small hooded clitoris and urethral meatus distinct from the vaginal introitus, both of which are located between separated labia. However, phenotypic genital components are defined as "ambiguous" when one of the following is present: (1) a small, hypospadiac phallus and a unilaterally undescended gonad; (2) an enlarged phallus with bilaterally impalpable gonads; or (3) an enlarged phallus and a vagina in the same infant.

When a child is born with ambiguous genitalia, the diagnostic evaluation and medical management of that child will require the expertise of several specialists. The neonatologist and pediatrician usually provide routine care of the newborn and often treat fluid or electrolyte disorders, while a geneticist assesses the child for any underlying chromosomal abnormality that expresses itself as an intersex disorder. A radiologist often uses diagnostic imaging techniques to better assess the internal accessory sexual organs of the child. However, it is often the role of the pediatric urologist to explain to family members the "am-

biguous" reproductive anatomy and what impact that circumstance may have on the future of the child. In addition, the urologist is often the surgeon chosen to perform required corrective or reconstructive surgery.

Children born with ambiguous genitalia need to be evaluated, and oftentimes treated, in an expeditious manner. At the same time, their parents need an informed, sensitive approach from the physician. Before evaluation of the child is discussed with the parent, it may be best to first provide them with an overview of normal sexual differentiation and development.

Normal Development

Embryology of the Genitalia

During normal sexual differentiation, the chromosomal sex determines the gonadal sex. In response, the gonadal sex determines the phenotypic sex, or the appearance of the external genitalia. The chromosomal sex is established at the moment of fertilization. If the fertilizing sperm contains an X chromosome, the zygote is 46, XX (female). However, if the fertilizing sperm contains a Y chromosome, the resulting zygote is 46, XY (male). The distal end of the short arm of the Y chromosome contains the testis determining factor (TDF) gene. The TDF gene is believed to provide the initial trigger mechanism for testicular differentiation and, most likely, to regulate the transcription of a cascade of genes necessary for testicular development from the undifferentiated gonad.

Unlike the determination of the chromosomal sex, which occurs at the moment of fertilization, the gonadal sex takes longer to develop. During the third to fifth weeks of gestation, undifferentiated gonadal ridges develop just lateral to the midline of the dorsal surface of the fetus. The development of the gonadal ridges parallels the development of the primitive mesonephros. Primordial germ cells initially develop in the primi-

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Ambiguous Genitalia

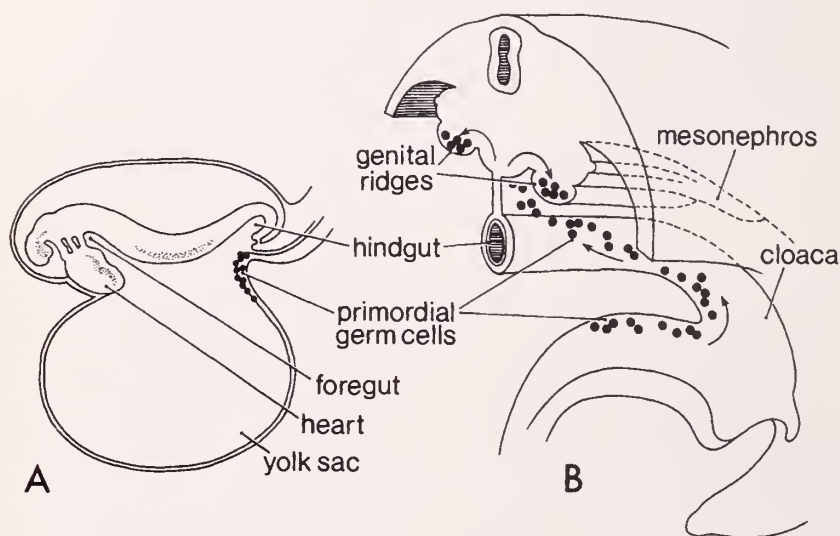


Fig 1 — (A) Schematic drawing showing the site of origin of the germ cells in the wall of the yolk sac in a 3-week-old embryo. (B) Migratory path of the primordial germ cells along the wall of the yolk sac and dorsal mesentery and into the genital ridges. (With permission from Langman J. Medical embryology; 4th ed. Baltimore: Williams and Wilkins; 1981; p 245.)

tive gut but then migrate to the undifferentiated gonadal ridges (Fig 1). The undifferentiated gonads then contain the primitive germ cells, supporting cells, and stromal cells.

Gonadal Development

In the male fetus, the undifferentiated gonad begins to differentiate into a testis during the seventh week of gestation. The support cells, called Sertoli cells in the male gonadal ridge, start to aggregate into early seminiferous tubules. The Sertoli cells then secrete Müllerian-inhibiting substance (MIS) at about the eighth to ninth week of gestation. MIS causes regression of primitive Müllerian structures in the male. Leydig cells, which are a type of stromal cell within the primitive gonad, begin to secrete testosterone around the ninth week of gestation, but it is still unclear what stimulates the Leydig cells to do this. Some believe the cells are being stimulated by placental gonadotropins,² while others believe the Leydig cells are responding to the fetus' own pituitary-hypothalamic axis.³

In the female fetus, estrogen synthesis occurs in the primitive gonad at about the same time as testosterone synthesis occurs in the male gonad. In the female gonad, however, histologic organi-

zation does not occur until roughly the fourth month of gestation. At this time, the stromal oocytes organize around the egg cells. Therefore, in the immature ovary, there is hormonal production prior to distinct ovarian histologic organization.

Internal Reproductive Development

The internal accessory reproductive organs of both sexes are derived from the primitive mesonephric kidney (Fig 2). Although most of this embryologic structure degenerates, a number of its remaining tubules fuse and form the Wolffian and Müllerian ducts that lie parallel to each other and join at their caudal end to become the urogenital sinus. By the eighth to ninth week of gestation, the gonads are no longer indistinguishable. In the male, the Müllerian ducts degenerate in response to the secretion of MIS by Sertoli cells. Testosterone, secreted by nearby Leydig cells, induces the Wolffian duct to differentiate into the epididymis, the vas, the ejaculatory duct, the seminal vesicle, and the vestigial appendix epididymis. The internal reproductive development is complete at the third month of gestation with the inhibition of the Müllerian structures and the virilization of the Wolffian ducts.

In the female fetus, the Müllerian ducts develop instead of degenerate because there are no Sertoli cells to secrete MIS. Further, since there are no Leydig cells in the fetal ovary to secrete testosterone, the Wolffian ducts do not virilize. Therefore, by the third month of gestation, the cranial ends of the Müllerian ducts have become the fallopian tubes, and the caudal ends have fused as a septated uterus (Fig 2). The septum then essentially becomes incorporated into the uterine wall, and a single uterus and proximal vagina develops. The Wolffian ducts degenerate to the vestigial epoophoron and paroophoron of the broad ligament as well as Gartner's duct.

External Genital Development

The appearance of the external genitalia (phenotypic sex) is determined by the gonads. External male genital development is influenced by gonadal androgens, but not specifically testosterone. It is primarily directed by dihydrotestosterone (DHT), which is testosterone that has undergone reduction by 5 alpha-reductase enzyme. In the male, DHT causes the external genital fold to enlarge and migrate medially. The genital fold develops into the urethral plate, and the genital tubercle becomes the glans and phallus

(Fig 3). The urethral plate elongates and tubularizes forming the urethral groove, and then finally becomes the urethra. At the same time, the genital swellings become the scrotal swellings, and eventually, the scrotum. The prepuce envelops the glans of the phallus and becomes the foreskin.

Development of the external female genitalia (Fig 3) begins around the tenth week of gestation. The genital swellings become the labia majora, and the urethral folds become the labia minora. The genital tubercle becomes less prominent in the female and regresses to become a hooded clitoris. External genital development is usually completed by the 14th week of gestation.

Ambiguous Genitalia

When a newborn child with ambiguous genitalia is first evaluated, the task may initially seem over-

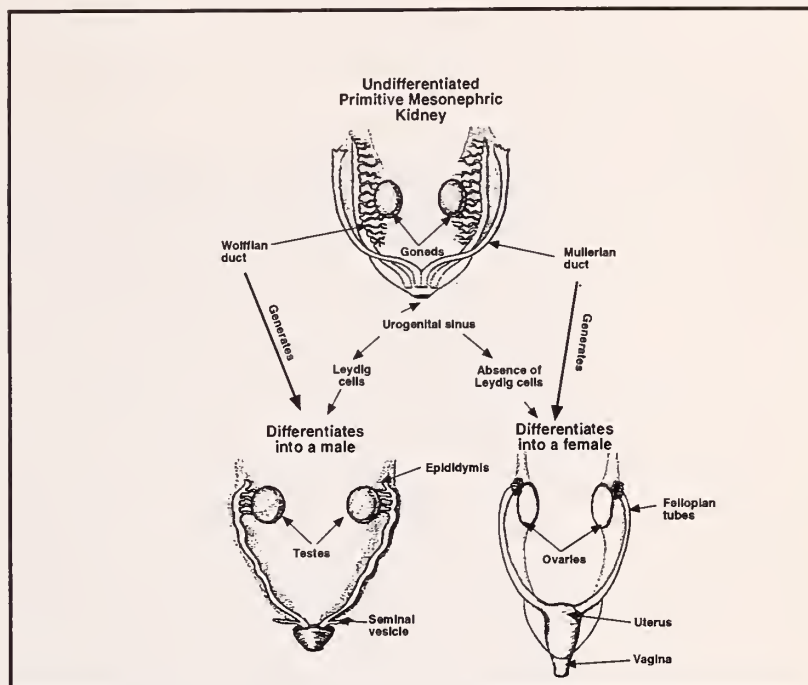


Fig 2 — Development of the internal genitalia from the undifferentiated stage.

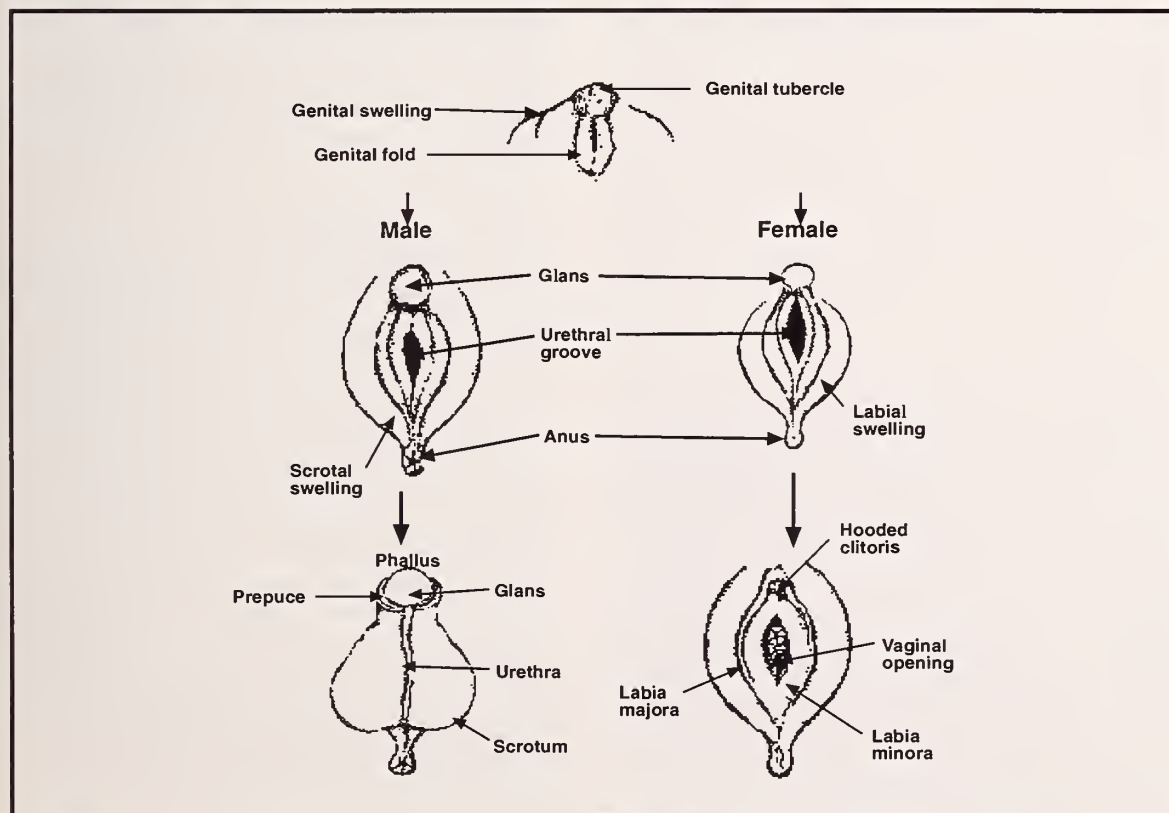


Fig 3 — Development of the external genitalia from the undifferentiated stage.

Ambiguous Genitalia

whelming. The clinical spectrum of what can be seen of the external genitalia can be quite broad, which is why, as in many fields of medicine, an attempt has been made to classify and categorize data that initially appear to be very complex. Intersex disorders can be classified by a number of different systems. Some of these are organized according to the chromosomal composition or the appearance of the external genitalia.

The most popular classification system of ambiguous development is based on the histology of the gonad, with a subclassification system based on the etiology, as proposed by Allen.⁴ In other words, the type of classification ascribed to a child is dependent on the type of gonadal tissue present in the child. Five intersex disorders are shown in Table 1. The terms for these classifications are somewhat arbitrarily chosen to assist the physician in understanding the disorders and their etiology.

Female Pseudohermaphroditism

Female pseudohermaphroditism is the most common cause of ambiguous genitalia, occurring in 60% to 70% of children born with ambiguous genitalia.⁵ Based on this classification, the child has two ovaries and a 46, XX genotype. The external genitalia, however, are virilized and ambiguous. The term "female" is used in this classification to indicate that the child has ovarian gonadal tissue only. The term "pseudohermaphroditism" is used because the external genitalia is somewhat virilized and has the appearance of being hermaphroditic, although it truly is not. Since the gonads became ovarian in light of the XX genetic composition, the internal Müllerian duct structures developed into fallopian tubes, a uterus, and a vagina.

The most common cause of female pseudohermaphroditism is congenital adrenal hyperplasia (CAH).⁵ The adrenal glands of children with this condition have an enzymatic defect in their conversion of cholesterol to cortisol. Therefore, serum cortisol levels are low and lead to an elevated adrenocorticotrophic hormone (ACTH) level and later to hyperstimulation of the adrenal glands and overproduction of adrenal androgens, including testosterone. In 95% of children with CAH, the deficient enzyme is 21-hydroxylase.⁶ It is important to remember that these young girls are potentially fertile.

Male Pseudohermaphroditism

A child with male pseudohermaphroditism has

Table 1. Classification of Five Intersex Disorders

Female pseudohermaphrodite
Male pseudohermaphrodite
True hermaphrodite
Mixed gonadal dysgenesis
Pure gonadal dysgenesis

testes and a 46, XY genotype. However, the phallus is very small or severely hypospadiac, and the testes may not have descended within the scrotum. Male pseudohermaphroditism can be caused by various disorders, deficiencies, and defects during the sexual differentiation period. Eighty percent of children with male pseudohermaphroditism have an antigen insensitivity⁷ that is usually due to an antigen receptor disorder. Most of the other 20% of children may have testes, but their Leydig cells may not be producing adequate testosterone, or the child may have a deficiency of 5 alpha-reductase enzyme. This enzyme is needed to convert testosterone to the active DHT, and the androgen DHT is needed to induce virilization of the external male genitalia. Such enzymatic defects that lead to male pseudohermaphroditism are very rare, though. Since many affected children have only a partial insensitivity to androgens, the extent of virilization varies considerably.

True Hermaphroditism

True hermaphroditism is very rare and occurs in only 10% of all children born with ambiguous genitalia.⁸ According to this classification system, a child with true hermaphroditism has both ovarian and testicular tissue. Fifty-seven percent of these children are genotypic 46, XX, with the TDF gene attached. Thirteen percent are genotypic 46, XY and 30% have chromosomal mosaicism.⁹ The appearance of the external genitalia varies from extremely virilized to extremely feminized.

True hermaphroditism is divided into three different categories. The child with **lateral** true hermaphroditism has a testis on one side and an ovary on the contralateral side. Children with **unilateral** true hermaphroditism have an ovotestis on one side and a normal gonad on the contralateral side. Children with **bilateral** true hermaphroditism have two ovo-testes.

Mixed Gonadal Dysgenesis

Mixed gonadal dysgenesis is the second most

common cause of ambiguous genitalia in the newborn. Most of these children are born with a 45,X/46,XY chromosomal mosaic pattern and have a testis on one side and a streak gonad on the contralateral side. Since the streak gonad does not produce MIS, the children usually have a unicornuate uterus and a fallopian tube on the same side as the streak gonad. The contralateral testis is dysgenetic and does not produce sperm. Therefore, as adults, these patients are sterile.

Pure Gonadal Dysgenesis

Although pure gonadal dysgenesis is included within this classification system of intersex disorders, it is not a cause of ambiguous genitalia. Children with this disorder have a 46,XX genetic composition and normal external female genitalia, but with bilateral streak gonads. These children usually seek medical advice for pubescent amenorrhea. This condition is very rare, and the girls are sterile.

Diagnostic Evaluation

Once the normal embryologic genital development and the various intersex disorders that cause ambiguous genitalia are reviewed with the parents, the family is better prepared for the diagnostic evaluation phase. By preparing the parents in this manner, most are able to understand the spectrum that exists between virilized and feminized genitalia, but it may also be helpful to emphasize the similarities between the two sexes and the homologous organs that develop. I inform parents that their child has genitalia that are neither extremely virilized nor feminized and explain the possible causes for the ambiguity. I then inform them that the task ahead is to determine what their child's internal reproductive anatomy is, as well as to understand what factors led to the ambiguity. The reason that children require a thorough and expeditious evaluation is not only to alleviate the fear and anxiety the parents may be experiencing but also to address the life-threatening nature of some of the causes of intersex disorders.

The evaluation should begin with a patient history and physical examination (Table 2). The focus of the patient history should be on the familial history and the history of the pregnancy. Assessment of the family history should include any prior pregnancies that ended in fetal demise or early infant deaths. The physician should inquire about relatives with a history of infertility or sterility

as well as possible consanguinity. When focusing on the history of the pregnancy, the physician should inquire about any hormonal ingestion or pharmaceutical exposures.

The physical examination should begin with an overall assessment of the child. Since some of the enzymatic deficiencies of congenital adrenal hyperplasia can lead to salt-wasting and dehydration, the physician should ensure that the child has good skin turgor and tears when crying. The focused examination can then proceed to include assessment of the abdomen and inguinal regions to inspect whether undescended gonads may be present. The physician should then visually examine the external genitalia and make a number of assessments. The phallus should be inspected for length, ventral curvature, appearance of the foreskin, and location of the urethral meatus. The scrotum or labia should also be examined. Is there a separation between the two halves of the labio-scrotal tissue, or are they fused? Are gonads present within the labio-scrotal tissue? Is there an obvious vaginal introitus? A gentle rectal examination may demonstrate the presence or absence of a uterus.

Since some of these conditions are associated with potentially life-threatening electrolyte disorders, serum electrolytes should be monitored closely. Serum levels of 17-hydroxyprogesterone as well as urinary levels of 17-ketosteroids can be elevated in patients with some types of CAH (Table 2). These levels can easily be assessed and provide useful diagnostic information. A chromosomal analysis should be started immediately since it usually takes several days to perform.

Table 2. Patient Evaluation

Patient History
Pregnancy history
Family history
Physical Examination
Abdomen and pelvis
Genitalia
Rectum
Chromosomal Analysis
Assess and Follow Serum Electrolytes
Measure Serum 17-Hydroxy Progesterone
Normal range = 82 to 400 ng/dl (1- to 5-day-olds)
Measure Urinary 17-Ketosteroids
Normal range = <1 mg/24 hours
Radiographic Imaging
Abdominal and pelvic ultrasound
Genitogram

Ambiguous Genitalia

Radiographic diagnostic imaging should begin with an abdominal and pelvic ultrasound. The presence of a uterus and intra-abdominal or intrainguinal gonads can easily be assessed in this manner. A slightly more invasive imaging study is the genitogram, which consists of inserting a small feeding tube catheter into all perineal orifices. Radiopaque contrast material is gently instilled, and the urethra or urogenital sinus and vaginal introitus can be visualized. On occasion, an endoscopic evaluation of the urethra or urogenital sinus is needed. Rarely are laparotomy, laparoscopy, or gonadal biopsy needed for a definitive diagnosis and assignment of a "sex of rearing."

Intervention and Management of the Child Ambiguous Genitalia

The goals for evaluating and treating these children are multiple, but the highest priority is to ensure that all electrolyte and endocrinologic abnormalities are addressed and corrected. This may require fluid resuscitation to correct dehydration as well as cortisol replacement. This treatment may inhibit subsequent overproduction of pituitary ACTH and help reduce the elevated serum androgen levels. The exact dose of the cortisol is dependent on the severity of the enzyme deficiency.

The next important goal is to assess the child's internal and external genital anatomy and assign a sex of rearing. This is usually based on several factors. It is generally believed that children with female pseudohermaphroditism should be reared as females. The vast majority of these children are females with congenital adrenal hyperplasia. They have normal internal reproductive anatomy with virilized external genitalia. Their genitalia often becomes less masculinized after cortisol replacement is initiated. If necessary, a feminizing genitoplasty, including clitoral reduction with preservation of the clitoral neurovascular bundle as well as exposure or creation of a vagina, can be performed as needed.

The sex of rearing for children with male pseudohermaphroditism is usually determined by the size of the phallus and ability of the erectile tissue to respond to androgens. Most physicians believe that it would be cruel to assign a child to the male sex of rearing if there is a very diminutive penis that is unresponsive to androgens. Therefore, many children with male pseudohermaphroditism, secondary to a partial or complete andro-

gen insensitivity, are reared as infertile females. Additionally some infants may need a gonadectomy to remove testicular gonadal tissue if the androgen insensitivity is partial. Otherwise, the child will begin to virilize during puberty at the time of their physiologic hormonal surge.

Similarly, the sex of rearing for true hermaphrodites depends on the size of their phallus and its response to androgens. If the phallus is of reasonable size, and the child is assigned to the male sex of rearing, any discordant or ovarian gonadal tissue should be surgically removed. On the other hand, if the child is assigned the female sex of rearing, testicular tissue should be removed to prevent further virilization. The latter children may also need a feminizing genitoplasty to reduce the size of the clitoris and give the perineum a more feminized appearance. Historically, 75% of true hermaphrodites have been reared as males, and 80% of them have hypospadias.¹⁰

Children with mixed gonadal dysgenesis pose more of a dilemma when it is time to recommend a sex of rearing. These children have a chromosomal mosaicism (45,X/46,XY) and a mixture of male and female internal and external genital anatomy. Internally, they have a dysgenetic testis on one side and a streak gonad on the contralateral side. They also usually have a fallopian tube and unicornate uterus. Historically, 60% of these children have been reared as females.¹⁰ Those who are reared as males are sterile and usually need to undergo hypospadias repair and gonadectomy. There is a significant incidence of seminoma, gonadoblastoma, or dysgerminoma arising in either the streak gonad or the dysgenetic testis.¹¹

Finally, since children with pure gonadal dysgenesis have female external genitalia, they do not usually seek medical advice until later in life when amenoreah occurs. If their chromatin contains elements of the Y chromosome, there is an increased incidence of tumors arising in the streak gonads. Therefore, it is recommended that the child undergo gonadectomy shortly after the diagnosis is made.

Conclusion

The causes of ambiguous genitalia are many, so it is important to approach these children in a systematic, stepwise fashion. Their evaluation should be done in an expeditious manner, with a multidisciplinary approach. It is very important to keep the parents informed during the evalua-

tion and allow them to understand the embryologic anomaly that leads to the genital ambiguity. Endocrine supplementation should be instituted when necessary, and a pediatric urologist should be actively involved in assigning the child's sex of rearing as well as performing any reconstructive surgery.

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Retroperitoneal Repair of an Abdominal Aortic Aneurysm Associated With a Horseshoe Kidney

R. Adoumie, MD; J. Hamman, MD

The presence of a horseshoe kidney may complicate surgery of the aorta. Abnormal renal anatomy, blood supply, and difficult exposure related to a bulky isthmus are commonly encountered. We describe a case where a left retroperitoneal exposure was successfully used to simplify many of these difficulties.

The presence of a horseshoe kidney (HK) is thought to occur in 0.25% of the population and is seen two to four times more frequently in men than in women.^{1,2} Despite this relatively high incidence, its coexistence with an abdominal aortic aneurysm (AAA) is rare (estimated at less than 90 cases in the English literature).²

A horseshoe kidney is often a benign finding, being asymptomatic in the majority of cases. Its presence in association with an AAA, however, might complicate repair significantly. This is primarily related to the abnormal renal anatomy and blood supply frequently encountered, and to the more difficult exposure.

Unusual arterial blood supply has been estimated at 60%. The number of renal arteries may vary between 1 and 10. Three general patterns have been described by Haimovici:^{1,3} (1) Single renal artery arising from aorta, 20%; (2) Three to five arteries to each kidney, all arising from aorta, 66%; (3) Multiple renal arteries to each kidney and isthmus arising from the aorta, iliac, sacral or hypogastric arteries, 14%.

The venous drainage is similarly variable and may parallel the arterial blood supply. But despite a seemingly rich blood supply, this is segmental with poor collaterals.

A number of ureteral anomalies have been described including multiple ureters to each kid-

ney. Fusion is typically but not consistently at the lower pole. In addition, the fused isthmus may vary from a thin fibrous band to a bulky overshadowing fusion.

Case Report

The patient is a 75-year-old male with a previous history of lymphoma. His chemotherapy was complicated by small bowel perforation with extensive abdominal soiling. The patient has been in remission, and on follow up CT scans, he was noted to have an enlarging AAA, now measuring 5.1 cm. His spleen remains markedly enlarged with secondary depressed platelet count.

Because of these considerations, including previous abdominal surgery and a bulky isthmus (Fig 1), a left retroperitoneal exposure was planned. A preoperative angiogram showed single renal arteries arising just above the aneurysm

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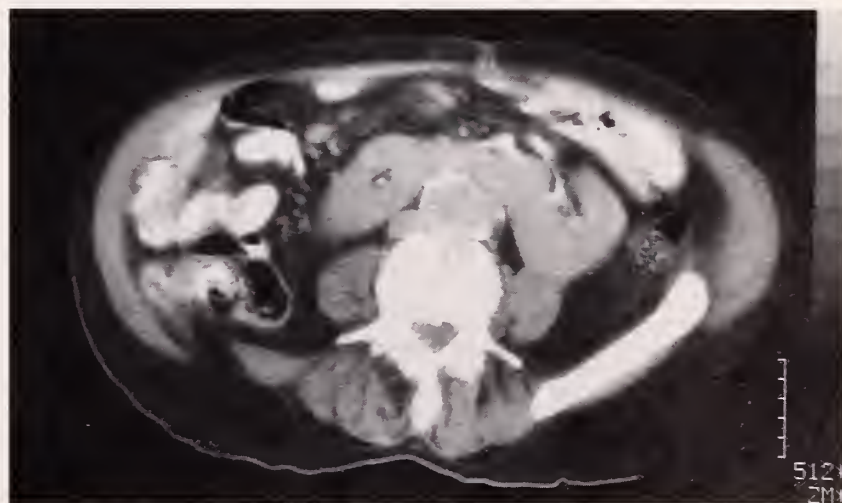


Fig 1 — Aneurysm overshadowed by a bulky isthmus.

sac. In addition the iliac arteries did not appear aneurysmal.

A left retroperitoneal exposure was performed through the tenth interspace with removal of the 11th rib.^{4,5} This allowed excellent exposure. A small anterior artery to the isthmus was noted arising from the aortic bifurcation. A tube graft was easily placed and a splenectomy was completed as planned preoperatively. Postoperative course was unremarkable with discharge on postoperative day five.

Discussion

The presence of a horseshoe kidney might significantly complicate repair of an aneurysm. The finding of HK may be suggested by ultrasound. CT scan, however, has better sensitivity and might help identify venous abnormalities that are more prevalent with this condition. A preoperative angiogram is indicated to define abnormal renal artery anatomy. Delayed films should show renal anatomy and obviate the need for an IVP.

A transabdominal exposure is still advocated by some surgeons,⁶ particularly in the presence of a large right iliac aneurysm. Division of the renal isthmus is rarely necessary and when needed could be accomplished fairly safely.

There is a concern, however, with the small but definite risk of urinary leak with a division.

A retroperitoneal exposure offers many advantages: Improved exposure, reduced risk for ureteral injury, and enhanced ability to endovascular reimplantation of anomalous renal arteries. In addition, as illustrated in this case, extensive adhesions associated with previous abdominal surgery can be avoided.

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Tornado Disasters and Stress Responses

Linda S. Godleski, MD

Each year, a number of tornados rip through Kentucky, leaving fear, destruction, and human injury in their path. Persons who endure these catastrophes often experience a variety of stress responses. The psychological and medical sequelae include depression, acute and post-traumatic stress disorders, substance abuse, anxiety, and somatization. It is especially important for the Kentucky practitioner to be able to recognize and screen for pathology following a tornado disaster in order to provide leadership in ascertaining treatment for such stress responses.

Tornados are devastating events that have fascinated us from "The Wizard of Oz" to last year's movie blockbuster, "Twister." In 1996 alone, 22 confirmed tornados touched down in Kentucky, injuring nearly 50 people and leaving massive destruction in their paths. The April 20 tornados in Berea, Kentucky, caused over \$12.8 million damage. The May 28 tornado was much more extensive, carving a 30-mile path through nine Kentucky counties, causing over \$100 million damage and destroying over 1500 homes, primarily in Bullitt County.¹

Studies of Catastrophes

We can anticipate responses to tornados by examining what has been learned from other disasters. The disaster literature can be divided into two categories: (1) man-made and (2) natural. Man-made disasters are subdivided into intentional (eg, war, murders, kidnappings) versus unintentional (eg, transportation and technological accidents, fires). Natural disasters are sub-classified by the type of event: weather (hurricanes, floods, tornados, etc) and non-weather/geological (earthquakes, volcanoes, brush fires, etc).

The first disaster studies were in response to war (man-made intended disasters). The effects

of war were described in the literature starting with World War I,² and continuing with World War II,³ Korean,⁴ Vietnam,⁵ and Desert Storm⁶ studies. More recent studies of man-made intentional disasters have expanded to reflect our increasingly violent society with an examination of the effects of mass murders,⁷ shooting sprees,⁸ and kidnappings.⁹

The analysis of man-made disasters proceeded from intentional to unintentional tragedies with the seminal publications following the Coconut Grove fire in Boston in 1942 which killed 491 nightclub patrons.¹⁰⁻¹² As a result of these studies, Lindemann¹² was the first to describe in detail the symptomatology and management of acute grief in his classic article. As society became more technologically advanced, the literature about the effects of man-made unintended disasters progressed to include nuclear disasters such as Three-Mile Island¹³ and Chernobyl,¹⁴ and transportation disasters such as plane crashes.^{15, 16}

The investigation of disasters shifted from man-made to natural starting in the 1950s.¹⁷⁻¹⁹ In the 1970s, following Hurricane Agnes' devastating effect in northeastern Pennsylvania, the Disaster Relief Act (PL 93-288) was passed. This gave the federal government the power to legislate disaster education and training. With more extensive mental health involvement, the natural disaster literature extended to intensively address weather disasters: tornados,²⁰⁻²⁴ hurricanes,²⁵⁻²⁸ floods,^{29, 30} and non-weather disasters: volcanoes,^{31, 32} earthquakes,³³⁻³⁹ and brush fires.^{21, 40-42}

Uniqueness of Tornado Disasters

Several characteristics specific to tornados impact their effect as a natural disaster. Tornados are unlike other natural catastrophes in being both: (1) relatively sudden, and (2) having the possibility of a warning, albeit usually a short one. In contrast, earthquakes and volcanic eruptions are sudden but without warning. Hurricanes, on

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Tornado Disasters and Stress Responses

the other hand, give rise to warnings, but are not sudden. The suddenness of tornados gives little time for emotional as well as practical preparedness. The potential warnings lead to both the "cried wolf phenomenon" (where inhabitants ignore warnings because previous ones were false), as well as "restimulation reactivity" or intense psychological distress and physical reactivity upon future warnings once a tornado has occurred. This is similar to the post traumatic stress symptoms of flood and hurricane victims⁴³ in bad weather.

The literature related to tornados began in the 1950s with Wallace's¹⁷ introductory work on the tornado in Worcester, Massachusetts. In the 1970s, one of the first detailed articles on mental health problems in tornado victims was written by Elizabeth Penick and Barbara Powell (along with William Sieck)²⁰ from the University of Kentucky and the Lexington Veterans Administration Hospital. They interviewed victims of the 1973 Joplin, Missouri, tornado that killed 87 persons and caused property damage for more than half its 40,000 inhabitants. About three-fourths of those interviewed 5 months after the disaster described emotional changes such as nervousness, tension, and minor somatic complaints. Additionally, many reported increased nervousness and fearfulness with stormy weather, an example of the restimulation reactivity described above. Seventy-five percent would turn to a family physician or clergyman, rather than mental health professional, if they felt they needed professional help.

The effects of the 1974 Darwin, Australia, cyclone were described by Raphael and Middleton.²¹ Since the storm occurred on Christmas Eve, the holiday mood and previous false alarms caught the residents off guard. This is reminiscent of the 1996 tornado warnings in the surrounding Louisville area on the eve of the Kentucky Derby, when many residents were actively engaged in pre-Derby partying, much of it outdoors. Fortunately, no tornado touched down.

Madakasira and O'Brien²² reported on the aftermath of a number of 1984 tornados which ravaged North and South Carolina. One tornado alone killed nine county residents, and total property damage exceeded \$100 million. Many residents reportedly ignored warnings as tornados were considered rare in those areas (a possible example of the "cried wolf phenomenon"). The researchers interviewed 279 of these tornado victims for evidence of post traumatic stress response. Fifty-nine percent met the criteria for post-

traumatic stress syndrome with symptoms of intrusive thoughts, increased startle response, increased reexposure tension, concentration and memory difficulties, and insomnia. Lack of social support systems seemed most correlated to severity of symptoms.

The Huntsville Tornado of 1989 spawned articles from a nursing²³ and psychiatrist's²⁴ perspective. The half-mile-wide tornado ranked 4 on the 0-5 Fujita severity scale, and devastated 16 miles, leaving 21 people killed, 463 seriously injured, and damage in excess of \$500 million. Even 6 months after the disaster, there was a significant need for child and adult mental health services. Many experienced post-traumatic symptoms of terror in stormy weather resulting in increased need for mental health services during severe weather times. Others became fearful on merely cloudy or windy days.

The Importance of the Primary Care Practitioner

The challenge for the clinician is to take what was learned from all of these disasters and extrapolate the results so that they are relevant to his or her practice. It is of particular importance to incorporate the types of stress responses, risk factors, and unique characteristics of tornado disasters.

The primary care practitioner is absolutely critical in screening for psychopathology after the disaster because many victims present with physical rather than psychiatric symptoms and initially seek medical rather than mental health follow-up. From 22% to 66% of post-disaster victims with psychiatric disorders present with physical symptoms.^{20, 41} As far back as 1944, Lindemann¹² emphasized the importance of physical symptoms in grief reactions, including respiratory abnormalities, fatigue, and digestive problems. In addition, many disaster victims are reluctant to use mental health services⁸ and are more likely to seek initial treatment with their primary care doctor.²⁰ Victims in smaller communities, like many in Kentucky, are even less likely to seek initial psychiatric treatment because studies have demonstrated that such persons are often very proud of their independence and self-sufficiency and have a limited understanding of mental illness.⁴⁴

When the primary care practitioner evaluates a person exposed to a disaster, it is important to realize that approximately one-fourth of all such persons will not demonstrate any impairing

sequelae, and one-fourth experience normal stress reactions.⁴⁵ Austin⁴⁶ describes normal reactions as anger, sadness, shock, irritability, apathy, agitation, and denial. In contrast, studies have demonstrated that approximately 50% of individuals can develop distinct psychopathology resulting from stress reactions that become disproportionate or prolonged.^{16, 21, 22}

The most common DSM-IV⁴⁷ diagnoses found after a disaster are major depression, post-traumatic stress disorder, generalized anxiety disorder, and substance abuse, in that order. Major depression occurred at rates of 41%, and higher in those with previous depression.¹⁶ Major depression is characterized by more than 2 weeks of depressed mood with thoughts of guilt, worthlessness, and death; with disturbance in sleep, appetite, energy, activity, concentration, and ability to experience pleasure.⁴⁷ Post-traumatic stress disorder on the other hand occurred from 22%¹⁶ to 59%²² as defined by more than 1 month of persistent intrusive thoughts, dreams, flashbacks, symptoms of arousal, and avoidance of stimuli associated with the trauma.⁴⁷ Generalized anxiety disorder is defined by excessive worry and apprehensive expectation for over 6 months,⁴⁷ and occurred at a rate of 20% to 29% following a disaster.¹⁶ Substance abuse was reported in 14% to 22%,¹⁶ and did not necessarily occur in pre-event abusers.

Studies have identified the following risk factors for post-disaster psychopathology: Women developed twice as many psychiatric disorders in Shore's studies;³¹ children and elderly were most vulnerable to disaster in Frattaroli's work;³⁵ decreased social supports increased vulnerability according to Murphy,⁴⁸ Farberow,⁴⁴ and Madak-sira;²² and lower socioeconomic status was correlated with increased post-disaster psychopathology according to Bolin.⁴⁹ Finally, disorders were greater with increased level and intensity of exposure to the disaster.^{16, 31} It is important, however, to note that Kiser⁵⁰ demonstrated that psychiatric disorders can occur even without direct exposure to the event — the mere threat of a New Madrid earthquake caused PTSD symptoms even without any actual disaster.

Conclusion

As residents of Kentucky, we all certainly hope that no major tornado disaster targets our state in the future. However, given destruction of the 1996 tornados, it is important for the practitioner to be

aware of what has been learned from previous disaster studies. In many cases, the primary care practitioner is the first and perhaps only person to screen for post-disaster psychopathology. Practitioner awareness of the connection between physical and psychological symptoms, psychiatric sequelae and general risk factors mentioned above, can lead to more accurate screening, diagnosis, treatment, and referral.

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He beat her 150 times. She only got flowers once.



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Breaking the Cycle of Domestic Violence: The Physician's Role

Baretta R. Casey, MD

The Kentucky Medical Association formed a Subcommittee on Domestic Violence over 4 years ago to educate physicians on issues of violence. Dr Casey chairs this committee.

Domestic violence affects millions of people each year. In the United States, two to four million women are battered annually by their partners. Although physical evidence may be limited to a single individual, all family members who witness the abuse suffer as well. The home becomes a place where violence can erupt at any time.

The effects of domestic violence are far reaching, affecting not only families but also communities, institutions, and society as a whole. It adversely affects the criminal justice system, social services, the legal system, the educational system, and the workplace. It also has significant effects on the health-care system.

Abused spouses and their children are our patients. So are the batterers. We treat injuries and illness — both physical and mental — directly related to the violence in their lives. Many victims are seen repeatedly before the domestic abuse is discovered. In some instances, the violence is never identified, and the physician continues to work up myriad complaints without making a definitive diagnosis. This adds to the high dollar cost of providing medical care to victims. It also prolongs the agony for families trapped in a repetitive cycle of violence.

For the health and safety of our patients and their families, it is imperative that we acquire the knowledge and skills to identify and respond appropriately to this pervasive problem.¹

To combat this problem, the Kentucky Medical Association formed a "Blue Ribbon" Subcommittee on Domestic Violence over 4 years ago to educate physicians on issues of violence. The Subcommittee is composed of a multidisciplinary group of physicians, prosecutors, social service representatives, judges, spouse abuse center representatives, and domestic violence prevention specialists. The Subcommittee has worked diligently over the past year to develop a *Model Health Care Protocol on Abuse, Neglect and Exploitation: Child, Spouse/Partner, Adult & Elder*. The goal of the Subcommittee this year was the development of a model protocol to facilitate quality health care intervention for abused patients and

to assist Kentucky's physicians to comply with standards, regulations, and laws related to adult and child maltreatment.

The development of the model protocol was prompted in part by a survey of physicians that the Subcommittee on Domestic Violence undertook regarding issues relating to reporting, documenting, and identifying domestic violence in their patients. The results of the survey indicated that physicians were interested in additional education on issues related to identification, reporting, and treatment of domestic violence.

Materials and Methods

In an effort to determine physician knowledge and response to domestic violence, a questionnaire was administered to practicing physicians across Kentucky.

Five hundred practicing physicians were questioned in a random survey, with 204 physicians responding. The physicians were randomly selected by service. Of those physicians who responded, 21% had been in practice less than 5 years, 38% had been in practice between 6 and 20 years, and 41% over 20 years.

The questions were written so responses would compare to a similar survey undertaken by the Jefferson County Medical Society in 1991-1992.² Each physician was asked if spouse abuse was reportable by law and to what authority it was reported if spouse abuse was suspected. The physician was then asked if any statute required their reporting of suspected cases. Also, the physician was asked that if no statute existed, should a statute be legislated to require a health care provider to report suspected spouse abuse. In addition, each physician was asked if he or she had ever reported spouse abuse (Table 1).

Results

Among physicians who responded to the 1996 KMA survey, 47% had filed a spouse abuse report as compared to 24% reported under the Jefferson County Medical Society study in 1991-1992. Also

DOMESTIC VIOLENCE AWARENESS SURVEY

1. As a medical professional, have you ever reported spouse abuse/domestic violence?
☐ Yes ☐ No
2. If you have ever reported spouse abuse, to whom did you report the confirmed or suspected abuse?
☐ Department for Social Services ☐ Police
☐ Other (please explain) _____
3. Does any state law require you as a medical professional to report confirmed and/or suspected spouse abuse to the appropriate authorities?
☐ Yes ☐ No
4. In your practice, approximately how many times a year do you see or suspect you have seen a patient who is a victim of spouse abuse?
☐ 0-5 ☐ 6-10 ☐ 11+
5. Do you think a state law should require you, as a medical professional, to report spouse abuse?
☐ Yes ☐ No
6. Do you think there needs to be more education opportunities in Kentucky for physicians on issues relating to identification, reporting, and treatment of domestic violence in your patients?
☐ Yes ☐ No
7. Have you attended any continuing medical education courses on issues related to identifying and reporting domestic violence?
in the past six months? ☐ Yes ☐ No
the past year? ☐ Yes ☐ No
post two years? ☐ Yes ☐ No
post five years? ☐ Yes ☐ No
If yes, where did you attend the course? (please explain) _____
8. What type of education on issues of domestic violence would be of interest to you as a medical professional?
☐ Video Course ☐ Didactic Lectures held in Regional Locations
☐ Journal Articles ☐ Specialty Society Seminars
☐ Other (please indicate) _____

in comparison to the 1992 study, of physicians responding, 59% were aware of the Kentucky statute requiring physicians to report confirmed or suspected abuse as opposed to 29% in 1992.

When asked about their opinion regarding the need for a statute requiring mandatory reporting of spouse abuse, 59% supported a mandatory reporting requirement for spouse abuse as opposed to 67% in 1992. However, when asked if more education opportunities for physicians are needed on issues related to identification, reporting, and treatment of victims of domestic violence, 76% of physicians agreed.

Discussion

In 1992, the Jefferson County Medical Society reported that issues of child abuse are well recognized by the medical community due to the fact that local medical organizations have placed a priority on their education. The results of the survey in 1992 highlighted this fact since over 80% of surveyed physicians were aware of the Kentucky statute which requires reporting of child abuse to the Kentucky Department of Social Services.³ The issue involved in this survey was follow up to the concern in 1992 that less than 30% of Kentucky physicians were aware of a similar statute requiring them to report confirmed or suspected spouse abuse.⁴

The improvement in the educational level of physicians regarding the statute requiring them to report confirmed or suspected abuse — from 29% in 1992, to 59% in 1996 — shows that the work of the Kentucky Medical Association, county medical societies, the two university medical schools, specialty societies, and individual physicians has been valuable to Kentucky physicians on issues of spouse abuse. While there has been an improvement, the Subcommittee on Domestic Violence seeks an even higher percentage and maintains a top priority of educating physicians on these important issues. The county medical societies, medical schools, specialty societies, and especially individual physicians should recognize their importance to patients and to continue educational opportunities on domestic issues.

Current Laws

Over the past several sessions, the Kentucky General Assembly has noted the urgency of the problem of spouse, child, and elderly abuse and enacted laws which protect victims of such crimes.

In 1996, the General Assembly passed HB 309 which established training requirements for professionals who deal with victims of abuse. Those professionals include social service workers who provide supervision or direct services at

Domestic Violence

the local/district/state level; staff agencies providing protective shelter services; Commonwealth's and County Attorneys; assistant County and Commonwealth's Attorneys; victim advocates; all law enforcement officers (state, county, metro), peace officers, sheriffs and deputies, and sworn enforcement officers with arrest powers; Circuit and District Judges, Domestic Relations and Trial Commissioners; Circuit Clerks and Deputy Clerks; and Nurses, licensed and certified mental health professionals, and Primary Care Physicians.

Each group of professionals is required to take various levels of training. Primary Care Physicians licensed in Kentucky must complete a three hour training course by June 30, 1999. Physicians licensed after this date shall complete the course within 3 years of initial licensure. The course will be developed by the Cabinet for Health Services in consultation with the Kentucky Board of Medical Licensure.

The purpose of the training is to educate professionals on the dynamics of domestic violence, legal remedies for protection, lethality and risk issues, available community services and victim services, and reporting requirements.

Current law under Kentucky Revised Statute (KRS) 209.030 requires physicians, law enforcement officers, health care providers, and others to notify the Cabinet for Families and Children of suspected adult abuse, neglect, or exploitation or spouse abuse.

KRS 209.030 states:

(2) Any person, including but not limited to physician, law enforcement officer, nurse, social worker, cabinet personnel, coroner, medical examiner, alternate care facility employee or caretaker, having reasonable cause to suspect that an adult has suffered abuse or neglect, exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.

(3) An oral or written report shall be made immediately to the cabinet upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: The name and address of the adult or any person responsible for his care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation including any evidence of previ-

ous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation.

According to KRS 209.030, if a physician has reasonable cause to suspect that an adult patient has been a victim of abuse, the physician is required by law to submit a written or oral report immediately to the Department for Social Services (DSS). Physicians may call the Adult/Child Abuse Reporting Hotline at 1-800-752-6200 or contact the local DSS office serving their county. The statute permits physicians and other health care providers to make reports to the Cabinet for Families and Children anonymously if so desired. The statute instructs physicians, health care providers, and others to provide as much relevant information as possible so the various social service and law enforcement agencies may thoroughly investigate the allegation and offer/provide protection and support services to the suspected victim.⁵

An advisory opinion issued in 1996 by the Kentucky Attorney General's office states:

It is the opinion of the Attorney General that the legislature intended to require physicians to report some cases of spouse abuse to the Department of Social Services. . . . Once a physician becomes aware of an abuse situation, in which the victim may be in need of protective services, he or she must determine who is inflicting the abuse. If the doctor ascertains that a spouse is abusing the patient, then the obligation to report is mandatory. The statute also addresses an additional scenario. If the physician is unable to determine who is inflicting the abuse, he or she must ascertain if the victim, because of mental or physical dysfunctioning, is able to manage his or her own resources and carry out the activities of daily living. In addition, the physician must determine whether or not the adult can protect himself or herself from neglect, hazardous or abusive situations, without the assistance from others. If the answer is no, and the physician decides the patient is in need of protective services, then again, the obligation to report is mandatory.

OAG 96-6

This interpretation of the reporting statute appears to be in conflict with past Attorney General opinions as well as the 18-year interpretation of the statute by the Cabinet for Families and Chil-

dren, Department for Social Services. The Attorney General opinion is nonbinding in Kentucky, and the existing statutory language remains clear regarding the responsibilities to report known or suspected adult maltreatment.

Patient-Physician Privilege

Reporting of suspected adult or spouse abuse is not a breach of the physician-patient privilege. KRS 209.050 specifically grants physicians immunity from civil or criminal liability for making a report of suspected abuse, neglect, or exploitation of an adult. If a physician or health care worker has "reasonable cause" to make a report, request an investigation, or assist in obtaining an emergency protective services for an adult pursuant to Chapter 209, then the physician or health care provider is granted immunity from civil or criminal liability.⁶

The General Assembly has imposed harsh penalties for any physician or health care provider who fails to file a report of suspected spouse abuse. According to KRS 209.990, any physician who fails to report known or suspected abuse may be found guilty of a Class B misdemeanor. Therefore, by continuing to ignore the duty placed on physicians and other health care practitioners by the General Assembly, members of the medical community are in jeopardy of not only civil suits and judgments, but may also face a criminal fine of \$500 and up to 180 days in jail.

Model Health Care Protocol

Educational opportunities for physicians on issues related to domestic violence are becoming more prevalent. The University of Kentucky College of Medicine and the School of Medicine have incorporated topics of child, adult, and elderly abuse into the curricula for the students and residents. While the physician's level of education may vary, *The KMA Model Protocol on Abuse, Neglect & Exploitation* is meant to give physicians a resource document and a guidepost for dealing with victims. While each patient may present his/her concerns differently, physicians should look for patterns of injuries like fracture(s) and trauma injuries (including teeth/mouth); bilateral, multiple or patterned injuries; injuries in various stages of healing. In addition, general symptoms may become apparent which indicate abuse, ie physical findings that appear inconsistent with medical history/statement of causation; delay between injury/condition and presentation; repeated visits

for treatment; over attentive parent, partner, or caregiver; or suspicious deaths/suicide (including attempts).

The protocol includes information on screening and identification issues; consent; assessment, examination, and documentation of abused patients; reporting responsibilities and medical records; model policy assessment forms, health insurance and reimbursement issues; legal issues; and patient education and referral information to community resources.

The model protocol will be mailed to physicians in April and seminars will be scheduled later in the year for which the protocol will be used as a guidepost to educate physicians attendees. The seminars will meet the requirement for primary care physicians, which as passed by the 1996 General Assembly through HB 309, specifies that licensed primary care physicians in Kentucky must attend a 3 hour training course on Domestic Violence by June 30, 1999.

Conclusion

The Subcommittee on Domestic Violence encourages physicians to utilize the KMA Model Health Care Protocol in caring for patients who have suffered abuse. Physicians should educate their office staff about how to handle these patients. The identification and proper referral of victims of domestic violence requires a team approach. Protocols must be accompanied by staff awareness and a commitment on the part of all providers to make domestic violence screening, treatment, and referral a high priority in their practices.

I encourage you to follow the theme of this year's Annual Meeting, "Patient Advocacy: The Physician's Essential Role," and become our patient's advocate regarding domestic violence.

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The Pap Smear, an "Endangered" Species

For decades, the Pap smear has been held up as the epitome of successful screening for cancer, with impressive declines in both development of and mortality from cervical cancer . . . from the leading cause of cancer death in the US prior to 1940 to one of the lowest at present. There are some disturbing trends however. Since 1987 there has been a slow rise in the incidence of this malignancy. Despite sensational front page news stories of cytologic malpractice, the real culprit is access. Up to 90% of the new cases of cervical cancer are due to lack of utilization of Pap smear screening, with only 3% due to screening problems or misinterpretation of the smears themselves.

In September, the KMA House of Delegates unanimously supported Resolution 125, which would do much to relieve one of the major impediments to realization of ensured continued access for the Pap smear. This resolution seeks to enjoin HCFA and managed care groups from categorizing Pap smears as a clinical laboratory test and to exclude it from clinical lab bids by third party payers. In addition, it requests that Pap smear screening be reclassified as a medical consultation. This resolution was referred on to the AMA and considered at its most recent interim session. Despite much support, it has been referred to the board for further consideration.

For years the Pap smear has been misclassified as a high-volume "for-bid" service — a practice utilized by third party payers as a cost-containment strategy and indulged by large laboratory vendors as a "loss-leader" to attract other more lucrative business. This practice, until recently held somewhat at bay by the constraints on increased cost due to CLIA-88, has resurfaced with the

onslaught on Kentucky healthcare by non-Medicare third party payers in the Bluegrass region. If permitted unchecked, this approach will serve to lead us to disastrous consequences with serious future Pap smear access problems.

As a high-volume utilization item, Pap smears have an annual outpatient consumption which approaches that of "wellness" monitoring tests such as cbc's and chemistry profiles. But volume utilization and consideration of aggregate cost are the only characteristics that these entities share. A Pap smear is not a "laboratory test." It should not ever have been considered as such, that having occurred to meet budgetary constraints of third party payers, notably Medicare. A Pap smear is a form of medical consultation, rightfully characterized as such within the statutes of The Bethesda System (TBS), a standardized format for reporting of cervicovaginal cytodiagnosis, now required for reporting by Medicare.

The problem is that Pap testing encompasses a broad range of service and diagnosis. At the least, Pap smears perform a screening function. Originally conceived by Dr Papanicolaou who engendered the five vague broadly interpreted Pap categories, this classification died as a victim of the Pap smear's success, succeeded by TBS which ascribes distinct diagnostic criteria for epithelial abnormalities and specimen adequacy. While Pap smears still provide this valuable screening function, they also yield invaluable diagnostic information at a level of sensitivity that surpasses even that of biopsy.

This function of screening cannot be separated from the function of diagnosis. Every slide is and must be at risk for direct review by a

pathologist. This direct relationship is underscored by liability for malpractice by that pathologist when a Pap smear result is found at variance with the clinical findings, even if he or she never saw the slide. A pathologist directs the review function, is responsible for quality assurance monitoring and for acceptability of all the myriad subfunctions and statistical accounting that the entire service engenders. A Pap smear is a medical consultation, not a lab test. A cbc or a glucose will never be subjected to this degree of scrutiny, regulatory bureaucracy, and personal review that a Pap smear receives.

This "high-complexity test" requires a sustained level of intensity of review unsurpassed in other fields of laboratory medicine. At a maximum through-put of 100 slides per day, each containing 100,000-200,000 cells, the cytotechnologist will look at 1.25-2.5 million cells in one hour, 10-20 million in a day. This for the price of a lunch for two at McDonald's.

What we have is a high-intensity, highly interpretive, problem-prone field encompassing screening, interpretive and diagnostic functions under escalating bureaucratic scrutiny and suffering tremendous reimbursement pressure. The coup de grace is the extreme liability crisis cytopathology currently faces. The Pap smear is now the single most common reason that pathologists are sued and the most expensive, so much so that insurance companies are seeking to place a surcharge on pathologists performing cervicovaginal cytology. It is not overstatement to say that there is a real danger of the demise of the widely available Pap smear.

With risk to reputation and livelihood, well-qualified pathologists

are leaving the field with few entering. If we compound this crisis with serious underpayment, an impending massive access problem looms. Already, an inordinate amount of time and dollars are spent to perfect a system which has been innately imperfect, subjective and interpretive, but relatively inexpensive. The standard of zero defects for Pap smears, guaranteed perfect outcome as required by the judicial system, is exorbitantly expensive, and \$10 from Anthem, or \$7 from Healthwise just won't cover it.

The exclusionary tactics practiced currently by "profits-conscious" providers are proving tragic for all except themselves. Big labs who are struggling to stay afloat with the aftermath of the Medicare imposed documentation of medical necessity, are experiencing mega-losses from these volume Pap smear contracts. This is manifested by National Health's recent poor showing in the stock market and SK's impending lay-offs in Lexington. Small volume laboratories who are excluded from the contracts due to reimbursement losses that they can't offset, lose "paying Paps" as well as the "for-bid" Paps since beleaguered office staff and physicians find it difficult to sort them out, sending them all to the high-volume "contract labs." Since the "break-even point" requires a certain number of payer mix cases, the logical choice is to chuck the scanty number of poor-paying high-risk cases for more stable business, with overall loss of providers.

Patients of the non-managed care product and the uninsured will pay handsomely in the short run (in our region both of the large lab vendors have increased Pap prices to offset these losses) as well as in the long run as survival of the remaining few large vendors will ensure a supply-side economic shortage with higher overall cost to society.

As stated by Dr Richard DeMay, a

cytopathology expert, (*Diagn Cytopathol*, Vol 15, Sept 1996, pp iii-vi) "Loss of the widely available, inexpensive pap smear will be a profound public health tragedy," — even more so in our state, identified as late as 8 years ago by the CDC as an endemic high risk area for cervical cancer.

The solution? I think that survival of the Pap smear is contingent on full "cost-plus" pricing. Profit margins for all labs and lab tests are falling to razor-thin levels. Laboratories, both large and small, are learning that financial survival is dependent on cost-based pricing for all lab services. Pull-through business with a limited profit margin does not offset major losses engendered by loss-leader pricing, and as the biggest loss-leader, Pap smears will become the stepchild of pathology.

Reasonable cost plus 12% to 15% is required. What is reasonable cost? Basing reimbursement on Medicare payment is creating much of the problem. There never was cost-accounting for Medicare's Pap fee schedule, merely budgetary constraints. The steady encroachment of OBRA and TEFRA has been contrary to market and societal pressures. The reasonable cost is probably \$14 to \$15. The Dark Report, an administrators' newsletter, in April of this year published that the cost of the Pap smear was somewhere around \$15 per case. In my laboratory, I have figured it as \$13.01 for a normal and \$16.01+ for an abnormal. An academic center nationally has published it as \$16.44 for a normal and \$18.45 for an abnormal. The biggest ticket item is the labor, running \$6 to \$8 for a highly efficient system and up to \$11 for labs which are heavily into quality assurance. Those labs who are costing it lower are tending to account Paps as incremental cost. Again, if they were realizing a profit at Anthem prices, why were the rates increased, up to \$39 at one lab, and why have

the turn-around times increased up to 3 weeks if reimbursement is not an issue? As one lab has stated, "What do they expect for \$10?"

I will close with a quote from a pathology newsletter — a pap smear provider decrying the reimbursement crisis: "What if patients knew that their . . . managed care organization was obtaining a test to screen for life-threatening disease for the same price as two Big Macs?" What if?

Susan E. Spires, MD
St. Joseph Hospital
Lexington, KY 40502
606/278-3436 (Ext 1802)

The Shoe on the Other Foot

I am quite certain that this scenario has never been enacted elsewhere except our household:

The tired physician comes home late in the evening to a laundry list of the day's woes from the spouse.

Says one, "you think you've had a hard day? Try responsibility for sick patients, constant crises, arguing all day with insurance companies . . ."

Says the other, "you have no appreciation for what I do; try running a household — the kids, the cleaning and shopping, taking care of bills. . .!"

Well, the good Lord, apparently having a keen sense of ironic humor, one day granted the wife her long-held desire, and suddenly she was transported — with little preparation or forethought on our part — to begin her first year in a medical school far, far away. As she rode off in her Jeep to begin her odyssey, I felt some vindication until I confronted the bewildered faces of two little boys, the whining of Molly the beagle, and a somewhat befuddled last-minute nanny. I choked back the sudden rise of panic and dutifully began to assume the role of Doctor Mister Mom.

All went well for, oh, about 24 hours. While the wife settled in with a load of books to begin the timeless student ritual of memorization of tomes of minutiae, I found out what it takes to prepare two small children for school each morning. It is akin to a juggler attempting to keep several spinning plates simultaneously balanced on precarious sticks. While the nanny prepared breakfast, I no sooner roused big brother half awake and began dressing the little one before the older brother slipped back

"It is amazing what insight and empathy can be gained simply by virtue of considering the other's predicament and situation."

into bed, curled up in sound sleep with the dog. The little one had to be suspended and jostled into his pants still asleep, his limp body plunged forward against my arms. The only time they seemed fully awake was at bedtime. And the day's tedium of innumerable phone calls from patients demanding refills on pain killers was interspersed with distressing phone calls from the school principal, teachers, and the nanny. It seemed that a day couldn't go by unless the nanny would call to inform me in grizzly detail on how yet another household appliance succumbed.

At night, the nanny bolted for her home as soon as I arrived, leaving me to the exasperation of two children not ready for bed yet. I am still in awe of the imaginative ways young children can misplace their pajamas or milk another bedtime story out of the old man; it gives me tearful hope for the survival of mankind. And on

many a late night, I would have the eerie sense of not being quite alone in a dark room aglow by the T.V. picture tube of adult programming. Indeed, after a furtive search, I would invariably spot the little round face of the youngest of the brood, parked behind me at the foot of the stairs, in wide-eyed silent awe of vivid images on the screen.

Meanwhile, the wife learned how to survive on little sleep, bad fast food and the tyranny of Black Mondays while digesting and recalling endless trivia. Quite different stresses now entered her life as well while she silently grieved for the temporary loss of family. One day, I visited her in the Anatomy Laboratory where I was assailed by pungent smells of preservation long forgotten. I found a studious, nice-looking young man, baseball cap on backwards, dissecting to the sounds of Disco and inquired of him where I might find my wife. He looked at me quizzically, then recalled, "Oh, you mean Dee! Yo, Dee, some guy here to see you!" "Dee?" I thought to myself, "Dee, the matriarch of our family, long-suffering, revered, middle-aged matron to our children and he just calls her 'Dee'?" Well, maybe I was a little jealous; after all, I still remember those beer parties after intense exams!

Back at the ranch, events continued down a slippery slope. Even little things around the house were intimidating. I, who can do a Whipple procedure with aplomb, was reduced to a cold sweat of indecision when working the washer and dryer — warm/cold? normal/heavy soil? cotton/sturdy or wrinkle guard? At dinnertime, howls of protest from the

boys would greet the latest proffering of food from the nanny. Frustration would turn into unmerciful teasing of the little one by big brother; the little one, not yet sophisticated in the art of verbal riposte, would respond by bouncing his spoon off of big brother's cranium, thus provoking a flurry of fisticuffs and flying macaroni. I yearned for an urgent call back to the hospital.

Then there was the nanny and her daily presentations of puzzling symptoms and aches defying rational explanation. There was the night I found her at home with lobster-red arms painfully stretched out to the sides, eyeglasses on the tip of a peeling nose. "I bin barn't," she cried out, thus clarifying her indiscretions under the sun lamp that day. The following week her car blew up in our driveway — literally — reduced to a smoking, hideous demise. Now I had to drive them all around until she found an equally tenuous coach to replace the first.

The summer break from school brought blessed relief when the haggard and worn Frau returned from the Front to set the household straight. "Now you'll get it," I cackled to the kids. "Wait till Mommy gets home and finds out what you've all been up to!" Whereas the boys and dog remained nonplus at months of my continuous threats and exhortations, simply the possibility of invoking the wrath of MOMMY induced wide-eyed trembling in boy and dog alike. True to form, she had the house back in order in two days. To snatch my last measure of justice, I insisted that she accompany me for one full day at work in the hospital. To my horror, however, during the very first surgery of the day, she fainted dead away, collapsing in a heap across the legs of a gratefully comatose patient. Though she claimed it was because she hadn't had breakfast, I still suspect it may have had something to do with my surgical technique.

Regardless, the exchange of roles had helped immeasurably in appreciating each other's responsibilities as well as accomplishments. And distance does make the heart grow fonder. It is amazing what insight and empathy can be gained simply by virtue of considering the other's predicament and situation. Perhaps we should all give it a try ever so briefly once in a while. After all, we are riders on this tiny planet together.

Epilogue: The nanny quit us after one year, preferring to pluck feathers at a chicken processing plant. The wife, children and dog have happily moved together until her graduation from school, thus relieving us all of guilt and allowing me to pursue a monk-like existence. God is in His heaven and all is at peace on this green earth.

Jaroslav P. Stulc, MD

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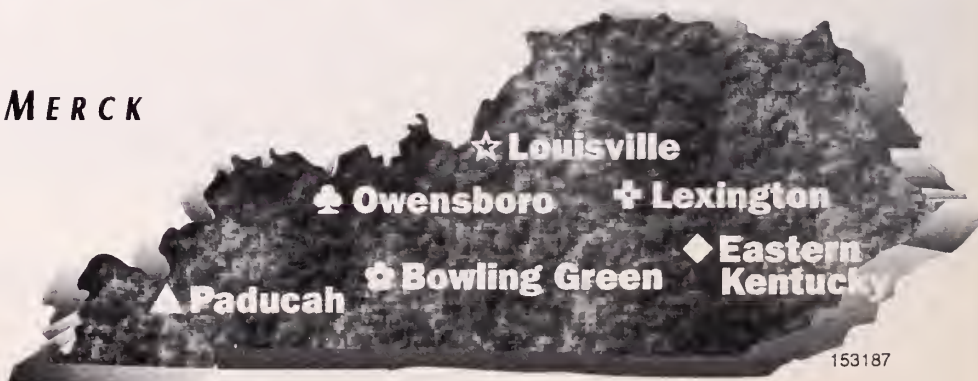


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Acknowledgment



Ruth Ryan

I wish to thank you, members of the Kentucky Medical Association Alliance, for granting me the honor of serving as your president this past year. It was indeed a privilege to witness your significant accomplishments in health education, community service, and political action. You understand the maxim that the most certain thing in life is change and, with your unity of purpose, talents, and compassion, you have met the challenge and performed remarkable feats.

I read recently that in 1906 when the Dow Jones Industrial Average surged above 100 for the first time, nobody paid attention. *The Wall Street Journal* simply noted the closing level in a table. When you Alliance members do what you do, though in a selfless and unassuming manner, I believe the fortunate people whose lives you touch *do* pay attention. Imagine the impact that you have in your communities and beyond through programs such as those I was given the opportunity to high-light in this KMA Journal:

- Boyd County's contribution to the American Medical Association Education and Research Foundation;
- Fayette County's anti-smoking

program, SMART, Students Made Aware Reject Tobacco;

- HIV/AIDS bookcovers/posters, initiated and promoted on a statewide level by the state president-elect, a member of Hopkins County Medical Alliance;
- Jefferson County's support for The Healing Place, a 115-bed homeless shelter; and
- Perry County's comprehensive health education program, Growing Healthy.

There will never be enough space available in this or any other publication to adequately celebrate your successes, but I would like to mention just a few more projects at this summing-up time:

- Daviess County's unusually generous medical scholarship awards;
- Henderson County's Doctor's Day project honoring physicians;
- Hopkins County's assisting the Mahr Center in screening for colorectal cancer;
- McCracken County's Rock N Bowl event to fund Allied Medical Careers Scholarships;
- Northern Kentucky's legislative efforts to help shape the future of medicine;

- Pulaski County's annual Health Fair; and
- Warren County's SAVE (Stop America's Violence Everywhere) Rummage Sale to benefit a shelter for victims of domestic abuse.

I challenge you resourceful Alliance members to continue your commitment to fellowship among physicians' families, education of children and adults toward a healthier lifestyle, preservation of rights through political activity, and enhancement of the positive image of medicine.

I especially wish to express my appreciation to Mrs S. Coates (Jean) Wayne, the KMA/KMAA Executive Secretary, for her dedication, efficiency, friendship, and good humor. Jean is responsible to a great degree for the continuity and prosperity of this organization.

Ruth Ryan
KMAA President

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PEOPLE

J. David Richardson, MD, a Louisville surgeon, has been elected vice chair-elect of the American Board of Surgery.

Brian Alpert, DDS, oral and maxillofacial surgery, surgical and hospital dentistry, University of Louisville, received the 1996 Harrigan Award for excellence and leadership in the field of oral and maxillofacial surgery at the 41st meeting of the William F. Harrigan Society held in December in New York City.

Included in a recent list of faculty promotions at the University of Louisville School of Medicine were KMA members **Marcello Pietrantonio, MD**, obstetrics and gynecology, associate professor, and **Stephanie P. Walton, MD**, medicine, assistant professor.

Richard S. Wolf, MD, and his wife, **Mary Burt**, were recognized during the unveiling ceremony of the statue "Wings" for their many contributions to the Kosair Children's Hospital in Louisville, including the special art and photography they helped collect. "Wings" completes the exterior of Kosair Children's Hospital and is the creation of artist Gary Price. It symbolizes freedom and the joy for life.

Shari Gabriel, MD, Louisville, has been appointed chief of Section of Orthopaedics at Kosair Children's Hospital.

UPDATES

KPC Needs Your Help

Kentucky Physicians' Care, now in its 13th year of service, provides access to medical services to uninsured Kentuckians with incomes at or below 100% of the Federal Poverty Level.

The Program provides free physician and hospital services, no-cost pharmaceutical products, dental care, hospice and home health services to eligible individuals. Participating physicians are asked to see eligible patients by appointment on a non-emergency basis, one time, at no charge. Financial arrangements for any subsequent visits, if necessary and agreeable to the physician, are at the discretion of the physician.

KMA is very hopeful that all Kentucky physicians will join their 1700 colleagues currently participating in this truly worthwhile program. The program has provided an estimated 61,000 physician referrals since 1985 and has received national recognition. Please call Brett Leichhardt at KMA (502/426-6200) for more information.

Workers' Comp Fee Schedule Now Available

The new Workers' Compensation fee schedule for physicians is now available from the Department of Workers' Claims. This fee schedule should be applied to all medical bills for services rendered on or after February 1, 1997. This new fee schedule completely replaces the 1994 medical fee schedule. It is available for \$35 in either hard copy or computer diskette. Checks should be made payable to the "Kentucky State Treasurer" and sent with your schedule request to: Department of Workers' Claims, Attention Administrative Services, Perimeter Park West, 1270 Louisville Road, Frankfort, KY 40601.

Please note that the request must include a return *street address* for shipping. The medical fee schedule *cannot* be shipped to a post office box.

CATO Society Semi-Annual Meeting

Sixty-eight physicians, spouses, and guests attended the 16th semi-annual meeting of the CATO Society held at the Community Health Building in Louisville.

CATO Society President **Eugene H. Conner, MD**, presented the Scroll Award to **Tom Jerry Smith, MD**, in recognition of his extended service to the medical profession and to patients, his family, and community during his 90 years.

Surgeon **William C. DeVries, MD**, presented the keynote address for the meeting. One guest, **Willard M. Posthuma, MD**, had received his surgical training with Dr DeVries' father at the University of Michigan prior to World War II.

Family Residency Program Opens in Glasgow

Governor Paul Patton announced January 30 the establishment of a new U of L family and community medicine residency program in Glasgow, KY.

He also participated in groundbreaking ceremonies for a \$15 million expansion of T.J. Sampson Community Hospital there, and heard about plans for a 6,300 square-foot clinic that will house the residency program's outpatient facilities.

The plan was developed by the University of Louisville School of Medicine's family and community medicine department, the South Central Area Health Education Center, and the hospital.

The hospital will have the only family practice residency program in the area. U of L has three other

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Louisville residency sites and is affiliated with one in Madisonville.

The new program eventually will include 12 residents and three full-time faculty members. The first four residents are scheduled to start work there this summer (pending accreditation approval).

The new clinic will feature a computerized medical records system and residents also will have access to computerized data bases to advance their knowledge. Plans also include interactive telecommunications with U of L's Family Practice Residency office to participate in conferences and grand rounds taking place at the Health Sciences Center in Louisville. Glasgow's electronic infrastructure also will make it easy in the near future to develop multimedia patient education materials, planners say.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Hazel Yang, MD —END
1200 Central Ave Ste 2, Ashland 41101
1980, U of Rangoon, Burma

Boone

Jeffrey B Gleick, MD —FP
PO Box 6148, Florence 41042
1993, U of Kentucky

Fayette

James F Elton, MD —AN
833 Palomino Ln, Lexington 40503-5458
1989, Emory, Atlanta

Robert M Geer, MD —FP
1221 S Broadway, Lexington 40504
1971, Northwestern, Chicago

Robert J Gewirtz, MD —NS
501 Burning Tree Cir, Lexington 40509-1934
1990, U of Cincinnati

William A Greisner III, MD —IM
4030 Bates Creek Rd Apt 2924, Lexington 40507
1991, Eastern Virginia, Norfolk

Paula Hollingsworth, MD —IM
179 Jesselin Dr, Lexington 40503
1991, U of Kentucky

Peter J Kambelos, MD —IM
1221 S Broadway, Lexington 40504
1993, U of Louisville

Luther C Pettigrew, MD —N
2035 Bridgeport Dr, Lexington 40502-2615
1980, U of Texas, Galveston

G Chris Stephens, MD —ORS
2316 Abbeywood Rd, Lexington 40515
1988, Vanderbilt

Vicky L Young, MD —PM
1736 Richmond Rd, Lexington 40502
1986, Med Coll of Wisconsin

Floyd

Tariq Muhammad, MD —NEP
40 Tara Ln Apt 11, Prestonsburg 41653
1988, U of Sind, Pakistan

Graves

Matilda Perkins, MD —S
1029 Medical Center Cir Ste 200, Mayfield 42066
1977, U of Texas, San Antonio

Hardin

Najam Azmat, MD —S
1230 Woodland Dr Ste 110, Elizabethtown 42701
1982, Khyber, Pakistan

Victoria M Baula, MD —PD
75 Woodsbend Dr, Elizabethtown 42701
1978, Far Eastern U, Philippines

Pedro S Baula, MD —PD
75 Woodsbend Rd, Elizabethtown 42701-9502
1978, Far Eastern U, Philippines

Harlan

Melchor J Aguilar, MD —R
81 Ballpark Rd, Harlan 40831
1971, Cebu Inst, Philippines

Jefferson

Ellen M Ballard, MD —PMR
250 E Liberty St Ste 800, Louisville 40202
1987, U of Kentucky

Mitchell J Campbell, MD —ORS
210 E Gray St Ste 900, Louisville 40202
1990, U of Louisville

Rodney V Chou, MD —PMR
14507 Maple Glen Plz, Louisville 40245
1992, U of Louisville

Swati M Daftary, MD —PMR
2805 Mockingbird Ct, Prospect 40059
1985, Government Med Col, India

Robert E. Darnell, MD —S
210 E Gray St Ste 604, Louisville 40202
1991, U of Louisville

Abby C Eblen, MD —END
9818 Willow Brook Cir, Louisville 40223-5337
1992, U of Tennessee

Melissa S Hancock, MD —PD
4007 Norbourne Blvd, Louisville 40207-3805
1993, U of Louisville

John E Harpring, MD —NS
4203 Stivers Ct, Louisville 40207-2883
1989, Wright State, Dayton

Robert Allen Lowenthal, MD —OPH
2324 Gladstone Ave, Louisville 40205
1991, Washington U, St. Louis

Allen Oladinni, MD —IM
14016 Hickory Ridge Rd, Louisville 40245
1984, U of Ibadan, Nigeria

Brian J Paradowski, MD —IM
3338 Indian Lake Dr, Louisville 40241
1993, Baylor

Behzad Parva, MD —PS
13418 Forest Springs Dr, Louisville 40245
1988, Temple

Anthony C Pearson, MD —C
7417 Cedar Bluff Ct, Prospect 40059
1980, St. Louis U

Gerard V Siciliano, MD —GE
3103 Chickering Woods Dr, Louisville

- 40241
1991, Mt. Sinai
George B Sonnier, MD —D
6410 Lime Ridge Place, Louisville
40222
1989, Louisiana State U, Shreveport
Gregory Evan Strull, DMD —DENT
4122 Shelbyville Rd Ste A, Louisville
40207
1990, U of Louisville
John G Van Savage, MD —U
210 E Gray St, Louisville 40202
1989, Vanderbilt
Lisa C Verderber, MD —OPH
3234 Running Deer Cir, Louisville
40241-6510
1990, Vanderbilt
Elisabeth C Von Bun, MD —ONC
1919 State St Ste 440, New Albany
47150
1988, U of Hamburg, Germany
Gregory S Walton, MD —R
14607 Woodlake Trce, Louisville
40245-5134
1990, U of Louisville
Andrew J West, MD —D
6400 Dutchmans Pkwy Ste 345,
Louisville 40205
1989, U of California, San Francisco
Arnold A Yashar, MD —ORS
2025 Kenilworth Pl, Louisville 40205
1990, Northwestern U Womans Med
Sch
Jessamine
Stella Rose Staley, MD —IM
3735 Harrodsburg Rd, Ste 140A,
Lexington 40513-1144
1985, U of Kentucky
Marion
Brian C Cusick, MD —OTO
315 W High St, Lebanon 40033
1985, U of Cincinnati
In-Training
Jefferson
Aftab Ahmed, MD —PMR
Peter Dedina, MD —IM
Steve K Jindal, MD —R
Jessica Dowe Robbins, MD —FP
Catherine Yashar, MD —GO

DEATHS

Patrick A. O'Neill, MD Owensboro 1921-1997

Patrick A. O'Neill, MD, a general practitioner, died January 8, 1997. Dr O'Neil was a 1955 graduate of the University of Louisville School of Medicine and an active member of KMA.

Everett G. Grantham, MD Louisville 1912-1997

Everett G. Grantham, MD, a retired neurosurgeon, died February 4, 1997. A 1935 graduate of Tulane University School of Medicine, Dr Grantham was a life member of KMA.

Karen S. Bakus, MD Louisville 1945-1997

Karen S. Bakus, MD, a pediatrician, died February 4, 1997. Dr Bakus graduated from the University of Louisville School of Medicine in 1970 and was an active member of KMA.

Michael P. Barron, MD Richmond 1939-1997

Michael P. Barron, MD, an internal medicine physician, died February 15, 1997. A 1967 graduate of the University of Vermont College of Medicine, Dr Barron was an active member of KMA.

Lyman G. Armstrong, MD Louisville 1938-1997

Lyman G. Armstrong, MD, an obstetrician-gynecologist, died February 19, 1997. Dr Armstrong served as president of Planned Parenthood of Louisville from 1983 to 1985 and was a volunteer physician for several homeless shelters. A 1967

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March 20 - Louisville

May 6 - Pikeville

Gearing Up for Retirement

April 23 - Louisville

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May 7 am - Lexington

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May 7 pm - Lexington

How to Run a More Profitable Practice

May 8 - Lexington

*If you would like more
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graduate of the University of Arkansas School of Medicine, Dr Armstrong was an active member of KMA.

Margaret B. Magruder, MD Paducah 1911-1997

Margaret B. Magruder, MD, a retired pathologist, died February 20, 1997. A 1944 graduate of Tufts University School of Medicine, Dr Magruder was a life member of KMA.

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Donald R. Stephens, MD Nominated for KMA President-Elect

Donald R. Stephens, MD, has been nominated by the Harrison County Medical Society for the office of President-Elect of the Kentucky Medical Association.

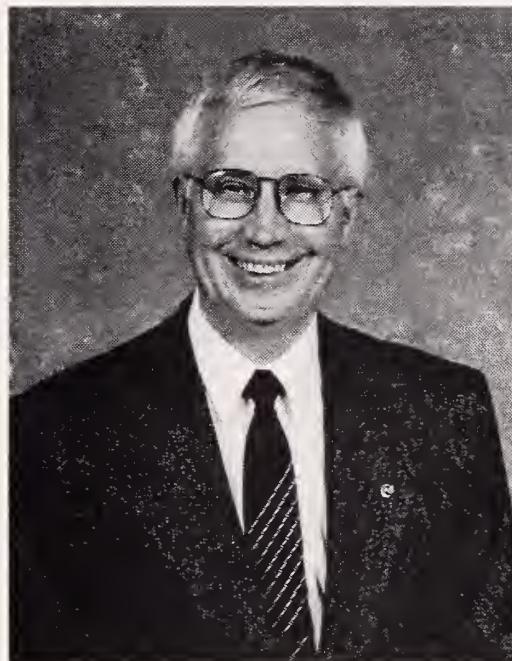
A family physician practicing in Cynthiana, Dr Stephens served 23 years as 9th District KMA Delegate, several years as an Alternate Trustee, and then three terms as Trustee. He Chaired the KMA Board of Trustees for two terms beginning in 1994, prior to his election as Vice President for 1995-96. Current commitments to KMA include service on the Professional Liability Committee.

Dr Stephens is a diplomate of the American Board of Family Practice, a charter fellow of the American Academy of Family Physicians, a member of numerous professional associations, and serves on the Associate Faculty at the University of Kentucky.

He is also committed to community and civic activities, having served on the Harrison County Board of Education for 18 years, including 2 years as Board Chair. He is a member of Covenant Presbyterian Church, where he has served as an elder for 28 years.

A native Kentuckian, Dr Stephens received an undergraduate degree from the University of Kentucky in 1956 and a medical degree from the University of Louisville School of Medicine in 1960. Following a rotating internship at St. Elizabeth Hospital in Dayton, Ohio, Dr Stephens began his practice in Cynthiana in 1961. That practice has continued to the present, with the exception of 1967-69 when he served his country in the US Army, including a one year tour in Vietnam.

Dr Stephens and his wife Sonia have five children and five grandchildren.



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American Heart Association	163	KMA Practice Management Seminars	165
American Medical Association	142, 162	KY Medical Insurance Company, Inc ...	Cover II
Astra Merck, Inc	160	Lexington Diagnostic Center	Cover IV
Baptist Healthcare System	168	MP System 2000	168
Classified	169	Medical Protective Co	159
Dean Witter	162	National Coalition Against Domestic Violence	149
Financial Architects	168	PIE	154
Impaired Physicians Program	162	U of L Dental School	160
KEMPAC	Cover III	US Air Force	166
KMA Annual Meeting	130		

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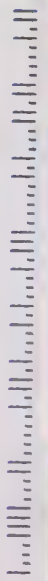
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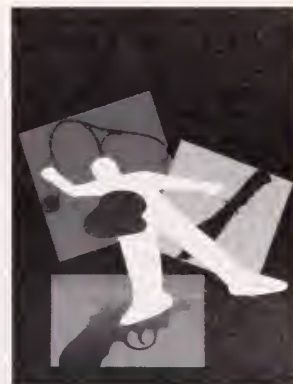


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MAY 1997



COVER: Workplace violence has become an increasing problem in the United States. This month's cover article reviews 40 such incidents of non-patient violence occurring in medical facilities. The results indicate that workplace violence in medical settings differs considerably from incidents in other work environments, particularly with respect to motivation, psychiatric diagnoses, weapons used, and stalking. See page 182.

COVER STORY	Violence in Medical Facilities: A Review of 40 Incidents <i>Theodore B. Feldmann, MD; Joseph Holt, MD; Scott Hellard, MD</i>	182
SCIENTIFIC	Wilms' Tumor in an Adult: A Case Report and Review of the Literature <i>David Butler, MD; John J. Buchino, MD; Baby Jose, MD; Robert D. Lindberg, MD; William J. Spanos, Jr, MD; Kristie J. Paris, MD</i>	191
	Tuberculous Lymphadenitis in the Adult <i>Catherine L. Sewell, MD; Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD; Jay B. Mehta, MD</i>	197
IN RETROSPECT	Medicine. . . 100, 75, & 50 Years Ago	200
EDITORIAL	Before the Plateau <i>Kimberly A. Alumbaugh, MD</i>	203
ASSOCIATION	<i>Monitoring Medicine</i>	179
	KMA Membership at UK Takes Dramatic Leap	208
	KMA Awards Nominations Form	207
	Application for Scientific Exhibits	215
	News	210
DEPARTMENTS	President's Page	177
	Advertisers' Guide	214
	Alliance Page	205
	Classified	213
	Information for Authors	196

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What's So Special About A Special Session



William H. Mitchell, MD

As physicians, we must approach any legislative activity as advocates for our patients. Tracking the political activities in Frankfort is like trying to get a drink of water out of a fire hydrant. There are several issues upon which our approach to the legislative session should be based. This will not be an easy task, but few things of value are easily accomplished.

Governor Patton has called a special session of the General Assembly in May 1997. The proposed special session will deal with higher education. This session may well be followed by a second special session dealing with Health Insurance Reform.

As you probably know, a special session is designed to be a one item session. The reason for calling special sessions is to limit, as much as possible, legislators "trading" votes on complex issues. A special session makes "vote trading" more difficult. The Governor calls the session and sharply defines the agenda for the session. Traditionally, effective Governors, like Governor Patton, reach a consensus with General Assembly leadership and have the

necessary votes before making "the call." In this instance, pay attention to "what the Governor does" rather than "what the media says." Health Insurance Reform votes may equate to votes on higher education.

In 1997, major changes have taken place within the Kentucky General Assembly. In January, when the General Assembly completed its

"Tracking the political activities in Frankfort is like trying to get a drink of water out of a fire hydrant. There are several issues upon which our approach to the legislative session should be based. This will not be an easy task, but few things of value are easily accomplished."

reorganization session, many of these changes took place. Most of these modifications took place in the Senate when Veteran Senate President John "Eck" Rose was replaced by Larry Saunders from Jefferson County. At that time, 15 Democratic Senators declined to serve as committee chairs. The announced constitution of the leadership of some committees is of particular importance to physicians.

Senator Benny Ray Bailey is now chair of the Senate Appropriations and Revenue Committee, one of the most powerful positions in the legislature. Senator Walter Blevins, a dentist, was elected to President Pro Tem of the Senate and has, in the past, been a major proponent of non-physician providers. Senator Ernesto Scorsone, who was a primary sponsor of House Bill 250, is Chair of the Senate Banking and Insurance Committee.

The new Senate rules may allow controversial social legislation to proceed from committee to the floor of the Senate. Intense debate on the chamber floors over social legislation has the potential to become significantly partisan and sometimes

personal. KMA becomes involved in social legislation which has medical implications. Consequently, these changes indicate that KMA has its work cut out for it as we prepare for a possible special session on Health Insurance Reform and the 1998 Regular Session.

On the House side, Speaker Jodie Richards of Bowling Green, Majority Floor Leader Greg Stumbo, and Speaker Pro Tem Larry Clark were all reelected. Jim Callahan of Northern Kentucky was reelected Democratic Caucus Chairman.

The House Health and Welfare Committee, which considers most medical legislation, is chaired by Tom Burch of Louisville. This committee appears to be fairly well divided among conservative and liberal members. On the House side there are 64 Democrats to 36 Republicans and on the Senate side, we find 20 Democrats to 18 Republicans.

The issues of Health Insurance Reform as it relates to changes created by House Bill 250 in 1994 and subsequently Senate Bill 343 in 1996 are as follows:

- Modified community rating
- Rate Hearing process
- High risk pool
- Provider sponsored networks
- Association health insurance plan exemptions

The main areas in this discussion that are pertinent to the KMA are as follows:

- Definition and length of pre-existing conditions
- Renewability
- Portability
- Guaranteed issue
- Maintenance of the Association exemption from Kentucky Kare

Many of these issues are covered under the federally enacted Kennedy-Kassebaum Health Insurance Portability and Accountability Act of 1996. Federal provisions primarily relate to group coverage. Several provisions require either state legislative or regulatory action and a specific timeline for implementation is required of states. One provision does mandate that acceptable alternative mechanisms must be implemented in the individual insurance markets by the states. In March, Governor Patton

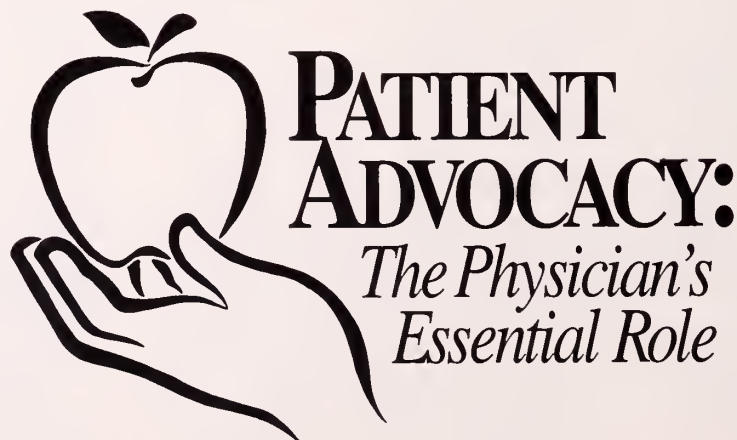
required all HMOs, which have been in operation for 2 years, to offer individual coverage. The Governor has indicated that many of the provisions of Kennedy-Kassebaum can be implemented through regulation rather than legislation.

Current issues regarding patient protection legislation might well find themselves discussed in any legislative special session on Health Insurance Reform. They include:

- Elimination of gag and hold harmless clauses
- Requirements that all managed care plans have a point of service feature for patients
- Require managed-care companies provide a due process provision to physicians before removing them from their panels
- Right of patients to be advised of specific plan requirements and exclusions

I welcome your counsel and advice as we deal with these issues as advocates of the best interest of our patients.

William H. Mitchell, MD
KMA President



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NEWS FOR KENTUCKY PHYSICIANS

KMA Endorses Patient Protection Concepts

In September the 1996 KMA House of Delegates designated Patient Protection legislation as a major priority for KMA's legislative effort. The KMA had previously introduced SB 365 which embodied principles of KMA's Patient Protection proposals during the 1996 Session of the General Assembly. Over the past several months, KMA has worked with Attorney General A. B. Chandler III on a legislative proposal to implement patient protection, which the Attorney General has labeled "patients right to know Act." On April 22 William P. VonderHaar, MD, Secretary-Treasurer of KMA presented the following testimony in support of Patient Protection before the Joint Interim Banking and Insurance Committee.

The KMA endorses the concepts Attorney General Chandler has outlined in his patient protection proposal. KMA, while expressing some reservations, has supported efforts towards managed care, gatekeeper provisions, and appropriate utilization review mechanisms that retain quality but curtail the cost of care. The Association worked very closely with the Cabinet for Human Services to develop and implement the nationally recognized KenPac program which assigns Medicaid patients to primary care physicians who manage their care, thus reducing unnecessary trips to emergency rooms, specialists, and subspecialists. That program has been successful, even though Medicaid officials now believe it does not go far enough.

Even though physicians have been supportive of changes in the delivery of medical care, there is heightened concern with insurers and managed care entities who routinely intervene in communications between the patient and physician. More and more, physician offices must deal with patients who find it impossible to understand poorly worded health insurance policies which give a false sense of security. Even though patients and physicians are given a number to call it is not uncommon to be placed on hold (we like to call it ignore) for long periods of time. Escalating and harsh retrospective reviews and denials of patient claims are the rule of the day.

In addition, all of us grow increasingly leery of capitation and other contractual agreements between physicians, insurance carriers, and managed care entities which increase the profit margin by reducing, delaying, or denying medical care. The reviewers and consultants who operate "incognito" from "afar" by "telephone" have little to fear. They don't have to face an elderly or confused patient or even the physician. Sadly, they rarely deal with fears of malpractice or liability for their decisions from "afar," due to the fact that the law usually insulates them from the consequences of bad judgements — which incidentally we hope the Kentucky General Assembly eventually addresses.

While there is no question that a balance was needed to reduce skyrocketing medical costs, the pendulum has now swung too far. We all read the horror stories of drive-through deliveries; brief stays for mastectomies and other serious surgical procedures; retrospective denials of emergency care that prudent individuals would characterize as a serious medical matter; and finally for the benefit of both patients and providers something must be done about the unconscionable delays in approving or paying for covered services. Unless something is done to curb such abuses, what you have witnessed so far is only a drop in the bucket as insurers and managed care entities scramble to protect the bottom line at



patients' expense. Corrective surgery is indicated along with a course of treatment to stop this vicious cycle of virtual immunity from public scrutiny and the baseless indifference toward patients and providers.

Attorney General Chandler is making a conscious effort to right the wrongs of overzealous insurers and managed care entities, who have no interest except the bottom line. We believe it is time to address abuses that serve to delay, deny, or reduce coverages, all under the guise of cost containment. In particular we implore you to address practices of some insurers and

managed care entities who routinely ignore patient and provider inquiries and complaints.

This experience has been an eye-opener for physicians, along with their patients, who have endured unnecessary interventions in the physician/patient relationship. Now we suddenly learn from insurance and managed care spokespersons that these problems NO LONGER EXIST — that objectionable provisions such as "gag" and so called "disparaging clauses" have been removed. We certainly hope they are headed for extinction. If what they say is true — we know why — the reason these

abuses are headed for extinction is due to the focus brought by federal and state governments, patient and provider complaints, and hearings like the one being held today. Insurance and managed care entities will tell you that legislation is unnecessary — that the problem has been corrected. Don't buy that argument. So long as this conduct is permissible — the abuses will return — probably shortly after you adjourn next April.

We encourage you to carefully consider Attorney General Chandler's initiatives and other measures that provide patients protection from overzealous insurers.

Certificate of Need

During the 1996 KMA House of Delegates, the Franklin County Medical Society introduced Resolution 96-118 entitled "Repeal of Kentucky Certificate of Need Law." The Resolution consisted of one Resolved.

RESOLVED, that the Kentucky Medical Association supports the repeal of Kentucky's Certificate of Need Law.

Reference Committee A after reviewing the matter concluded that, while there was general agreement with the sentiments for improvement or elimination of the CON process, the issue is not a simple one. The Reference Committee recommended that the issue (resolution) be referred to the Board of Trustees for further discussion. The 1996 House of Delegates concurred with the Reference Committee's recommendation.

The KMA completed an extensive study of CON and after considerable discussion the KMA Board of Trustees adopted the following position:

The KMA Board of Trustees reaffirms and endorses the retention of the Certificate of Need law with an option of reviewing modifications as periodically proposed. The KMA continues to support the preservation of the private physician's office exemption.

Prior to the Board of Trustees meeting on April 16, William P. VonderHaar, MD, Secretary-Treasurer of KMA, testified before the Interim Subcommittee on Health and Welfare at the request of Senate Health and Welfare Chair Julie Rose (R), Louisville. The Subcommittee is considering changes in the present CON law. Doctor VonderHaar's testimony was as follows:

The KMA appears today at your request to enunciate KMA's position on the Certificate of Need law. From its inception in 1972, the legislature granted physician offices exclusion from the provisions of Certificate of Need. On numerous occasions

since 1972, the Kentucky General Assembly has supported and reaffirmed the physician office exemption. That remains the position of the Kentucky Medical Association.

During the same hearing, a Kentucky Hospital Association spokesperson recommended that "CON regulations should define what constitutes a 'private physician's office' for the purpose of the CON exemption which is granted to such offices in the law." The KHA supports an old Attorney General opinion that defined physician offices as a specific building, room, or rooms not open to the general public, which the physician uses on a regular basis to provide health services to patients, and is not a health facility subject to licensure under the law. KMA objected to this proposal pointing out that physicians are no more interested in having their offices "defined" than they are in including physician offices under CON.

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Violence in Medical Facilities: A Review of 40 Incidents

Theodore B. Feldmann, MD; Joseph Holt, MD; Scott Hellard, MD

Workplace violence has become an increasing problem in the United States. This paper reviews 40 such incidents of non-patient violence occurring in medical facilities. Areas of study include categories of violence, weapons used, number of persons killed or wounded, precipitant for the violent act, and the presence of psychopathology. Additional variables such as suicide, drug and alcohol use, stalking, and hostage-taking are also examined. The results indicate that workplace violence in medical settings differs considerably from incidents in other work environments, particularly with respect to motivation, psychiatric diagnoses, weapons used, and stalking. Intervention and management strategies in health care institutions may, therefore, need to be modified in order to deal with violence. An examination of the data allows development of a profile for violence in medical settings and the identification of risk factors. Security issues for hospitals, clinics, and physician offices are also discussed.

Acts of violence in the United States have increased significantly in the past 15 years. According to the Federal Bureau of Investigation (FBI), violent crimes reported to law enforcement agencies increased 23% between 1988 and 1992, and 54% between 1983 and 1992.¹ During that same time span, the murder rate increased 11% compared to 1988 and 12% compared to 1983. It is unclear whether more recent data showing a decline in violent crime rates represent a true downward trend or merely a statistical anomaly.²

Violent attacks in the workplace have also escalated dramatically since 1980, with an estimated 1,400 people murdered on the job each year.³ Homicide now accounts for 17% of all occupational fatalities and is the second leading cause of death overall.⁴ For women, homicide is the leading cause of job-related death. It has been

estimated that 2.2 million workers are assaulted in the workplace each year.⁵

Workplace violence occurs across a variety of occupational settings. An ongoing study at the University of Louisville has previously reported that 13.9% of 240 workplace violence incidents occurred in medical facilities.⁶ That study has examined workplace attacks across the United States and Canada; incidents occurred in all 50 states and four Canadian provinces, and included both rural and urban areas. The current paper examines 40 incidents of violence in medical settings; these incidents were taken from a larger sample of 385 workplace violence incidents which were carried out in 11 categories of work environments (public/government facilities, offices, restaurants/bars, businesses, medical facilities, transportation centers, hotels/motels, convenience/food stores, retail stores, plants/factories, and media facilities). Data was collected on perpetrator demographics and psychopathology, motivation for the attack, precipitants and warning signs of impending violence, weapons used, and outcome. Security issues for health care facilities are also discussed.

Methods

For the purposes of this paper, violent incidents were defined according to the following criteria: (1) the incidence must have occurred in a health care facility; (2) an act of violence or aggression occurred which was of sufficient severity to merit reporting to a law enforcement agency; (3) if the incident was not reported to police, some action to address the situation had been taken by the facility (disciplinary action, counseling, restraining orders, etc); (4) if no actual violence occurred, a threat was made which was either reported to police or dealt with by hospital or clinic authorities; and (5) the perpetrator was not a patient at the facility.

From the Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, KY 40292, 502/852-5431. Dr Feldmann is Associate Professor of Psychiatry and Drs Holt and Hellard are Psychiatric Residents.

Violence in Medical Facilities

Variables examined include the setting in which the incident occurred, the motivation or precipitating event, weapons used, military history, excessive weapons interest, number of persons killed and/or wounded, whether warning signals of the attack were observed, the presence of stalking, and whether hostages were taken. Psychiatric variables included primary and secondary DSM-IV diagnosis, alcohol and/or drug use, psychotropic medications used, and suicide.

Results

Forty incidents of non-patient violence in medical facilities were examined. These incidents involved 38 individuals. All of the subjects acted alone, and one person was responsible for three separate acts of violence against medical clinics.

The mean age of the perpetrators was 35.4 years, with a range of 19 to 71 years. Thirty-two individuals (84.21%) were male. Whites accounted for 73.68% of the subjects, African-Americans represented 10.53%, Hispanics 7.89%, and Asian-Americans 5.26%.

Category

In this study, the category of violence refers to the primary identity and motivation of the perpetrator. Seven categories were identified: (1) disgruntled employees; (2) disgruntled former patients; (3) persons involved in personal/domestic disputes that were carried into the facility; (4) mentally ill persons for whom no other motivation was present; (5) criminals; (6) disgruntled students or trainees; and (7) abusive supervisors.

The categories of violence in medical facilities can be summarized as follows (see also Table 1): mentally ill, 14 (35%); abusive supervisor, 7 (17.5%); disgruntled former patients, 6 (15%); personal/domestic dispute, 5 (12.5%); disgruntled student/trainee, 4 (10%); disgruntled employee, 3 (7.5%); and criminal, 1 (2.5%).

Precipitant

Precipitants were defined as either *acute* or *insidious*. Acute precipitants include those for which there is little or no indication of impending violence. A situation occurs in which the perpetrator acts spontaneously with a minimum of planning or premeditation, or with few if any warning signals. Insidious precipitants, on the other hand, build over time and culminate in some violent action. These are usually the result of long-standing conflicts or grievances. Warning signals of

Table 1. Categories of Violence in Medical Facilities

Mentally Ill	14 (35%)
Abusive Supervisors	7 (17.5%)
Disgruntled Former Patients	6 (15%)
Personal/Domestic Disputes	5 (12.5%)
Disgruntled Students/Trainees	4 (10%)
Disgruntled Employees	3 (7.5%)
Criminals	1 (2.5%)
Total # of Medical Incidents	40 (100%)

impending violence are usually noted, and interventions to defuse the situation are either unsuccessful or not attempted. It was possible to identify some precipitating event in all 40 medical incidents. Acute precipitants were found in 4 cases (10%), while insidious precipitants were identified in 36 cases (90%). The majority of the insidious cases were related to abusive supervisors, disgruntled students/trainee, and personal/domestic disputes. The four acute cases all involved mentally ill subjects.

Military Service

Four of the perpetrators (10.53%) had military experience, and one was on active duty at the time of the incident. Half of these subjects had combat experience, all in Vietnam. All of the persons with military experience also fell into the category of excessive interest in weapons (see below).

Weapons

Many different weapons were used in these incidents; perpetrators often carried or used multiple weapons. Thus, the *total number of weapons* used was examined, as well as the *primary weapons* which inflicted the greatest number of injuries and fatalities (see Table 2).

Handguns (45.71%) and physical force (28.57%) were the most commonly encountered primary weapons. Physical force was defined as the use of hands, fists, or some other part of the human body to inflict injury. Other weapons, such as rifles, knives, assault weapons, or bombs, were used infrequently.

These weapons accounted for injuries or fatalities in 33 of the 40 cases (82.5%). A total of 28 deaths occurred (0.7 per incident), and 114 people were wounded (2.85 per incident).

Excessive interest in weapons was defined as an ongoing preoccupation with weapons and their use, or extreme fascination with military

and/or paramilitary activities. In this sample, 5 people (13.16%) demonstrated an excessive interest in weapons.

Stalking and Hostage-Taking

Stalking is defined as the unwanted or surreptitious following of a person for the purpose of harassment or some other criminal activity. Stalking of victims occurred in 27 incidents (67.5%). The categories in which stalking occurred most frequently were personal/domestic disputes, abusive supervisors, and disgruntled students/trainees. Ninety percent of the cases in which stalking occurred resulted in the death of the victim.

Hostages were taken in 5 incidents (12.5%). Data on both stalking and hostage-taking are presented in Table 3. All of the cases involving hostages were in the personal/domestic dispute and disgruntled student/trainee categories.

Psychiatric Diagnoses

Psychiatric diagnoses were found in 36 of the 38 persons studied (94.7%). Both primary and secondary DSM-IV diagnoses were recorded.⁷ In addition, primary and secondary psychiatric diagnoses were categorized according to broader diagnostic groups (eg, affective disorders, personality disorders, psychoses, etc).

The most common primary diagnoses were borderline personality disorder (18.42%), depression (13.16%), and pedophilia (10.53%). This material is presented in Table 4. The borderline personality diagnosis was found most frequently among the personal/domestic dispute and disgruntled student/trainee categories. All of these cases of pedophilia involved abusive supervisors who molested children in hospital or clinic settings. The most commonly encountered secondary diagnosis was alcohol abuse or intoxication (26.67%), found in the personal/domestic and disgruntled former patient categories.

Due to the large number of primary and secondary diagnoses, it is more useful to examine the diagnostic groups into which the perpetrators fell (see Table 5). Personality disorders accounted for the most frequent primary diagnostic group (31.58%); occurring most often in the personal/domestic dispute and disgruntled/student/trainee categories. Psychosexual disorders accounted for 21.05% of the sample and occurred exclusively in the abusive supervisor category. It should be noted that abusive supervisors were defined as those persons who had direct responsibility or control over others. Thus, abusive super-

Table 2. Weapons in Medical Incidents

Primary Weapon Used (N = 35 Weapons)*		
Handguns	16	(45.71%)
Physical Force	10	(28.57%)
Rifles/Shotguns	3	(8.57%)
Knives	2	(5.71%)
Assault Weapons	1	(2.86%)
Bombs/Grenades	1	(2.86%)
Hammer/Blunt Objects	1	(2.86%)
Bottle/Broken Glass	1	(2.86%)
Total # of Weapons	35	(100%)

* Weapons Actually Used to Inflict Injury/Death

Total Weapons (N = 47 Weapons)

Handguns	22	(46.81%)
Physical Force	10	(21.28%)
Rifles/Shotguns	4	(8.51%)
Knives	4	(8.51%)
Bombs/Grenades	3	(6.38%)
Assault Weapons	2	(4.26%)
Hammer/Blunt Objects	1	(2.13%)
Bottle/Broken Glass	1	(2.13%)
Total # of Weapons	47	(100%)

Table 3. Stalking and Hostage-Taking

Stalking		
Yes	27	(67.5%)
No	13	(32.5%)
Total # of Incidents	40	(100%)
Hostage-Taking		
Yes	5	(12.5%)
No	35	(87.5%)
Total # of Incidents	40	(100%)

Table 4. Primary Psychiatric Diagnoses

Primary DSM-IV Diagnosis (N = 38 Subjects)		
Borderline Personality Disorder	7	(18.42%)
Depression	5	(13.16%)
Pedophilia	4	(10.53%)
Polysubstance Abuse/Dependence	3	(7.89%)
Sexual Sadism	2	(5.26%)
Schizoid Personality Disorder	2	(5.26%)
Paraphilia NOS	2	(5.26%)
Conduct Disorder	1	(2.63%)
Schizophrenia	1	(2.63%)
Psychotic Disorder NOS	1	(2.63%)
Delusional Disorder, Paranoid Type	1	(2.63%)
Paranoid Personality Disorder	1	(2.63%)
Narcissistic Personality Disorder	1	(2.63%)
Delusional Disorder, Grandiose Type	1	(2.63%)
Delirium	1	(2.63%)
Post-Traumatic Stress Disorder	1	(2.63%)
Brief Psychotic Disorder	1	(2.63%)
Antisocial Personality Disorder	1	(2.63%)
No Diagnosis	0	(0%)
No Diagnostic Information	2	(5.26%)
Total # of Subjects	38	(100%)

Violence in Medical Facilities

Table 5. Primary Psychiatric Diagnoses by Group

Primary DSM-IV Diagnosis by Diagnostic Group (N = 38 Subjects)		
Personality Disorders	12	(31.58%)
Psychosexual Disorders	8	(21.05%)
Affective Disorders	5	(13.16%)
Psychotic Disorders	5	(13.16%)
Substance Abuse Disorders	3	(7.89%)
Disorders of Childhood/Adolescence	1	(2.63%)
Organic Mental Disorders	1	(2.63%)
Anxiety Disorders	1	(2.63%)
No Diagnosis	0	(0.00%)
Na Diagnostic Information	2	(5.26%)
Total # of Subjects	38	(100%)

visors could direct their actions against either staff members or patients. Affective disorders and psychotic disorders represented 13.16% each, primarily in the mentally ill category. Among the secondary diagnoses, personality disorders accounted for 46.67% and substance abuse disorders 33.33%; these were found most often in the personal/domestic dispute category.

Psychotropic medication use at the time of the incident was found in nine subjects (23.68%); the majority of persons taking medication were in the mentally ill group. Antidepressants were the most commonly encountered drugs (five subjects).

Alcohol and Drug Use

Alcohol use at the time of the incident was documented in eight perpetrators (21.05%). Drug abuse at the time of the incident was found in four subjects (10.53%). Cocaine and narcotic analgesics were the most frequently abused drugs in this study. It is interesting to note that alcohol and drug use occurred less frequently than might be expected. A prior history of substance abuse, however, was presented in two-thirds of the subjects.

Suicide

A completed suicide followed two incidents (5.26%), while suicidal threats or ideation was present in 12 additional cases (31.58%). Three suicide attempts (7.89%) were identified. No evidence of suicide was found in 20 subjects (52.63%). The categories most often associated with some type of suicidal preoccupation were personal/domestic disputes and disgruntled students/trainees.

Discussion

The literature on violence in medical settings has focused primarily on assaults committed by psychiatric patients against physicians or staff on inpatient psychiatry services.⁸⁻¹² Other reports have examined the problem of emergency room violence;¹³⁻¹⁷ these reports also focus on assaults committed by patients, usually in connection with psychiatric illness or substance abuse. Relatively little appears in the literature regarding the issue of non-patient violence in medical settings.¹⁶

In this study, violence took place across all types of practice sites including hospitals, clinics, private physician offices, and medical schools. Table 6 summarizes the characteristics of violence in medical settings. Offenders typically were males in their early to mid-thirties, who acted alone. In most cases, the perpetrator did not work in the setting where the violent act was committed. Approximately 90% of the subjects suffered from some diagnosable mental disorder; these people were rarely on psychotropic medication, implying either that they were not currently in treatment or had never sought treatment. Alcohol and drug use was relatively uncommon, with the exception of those incidents in the personal/domestic dispute category.

The seven categories of violence in medical settings reported in this paper have also been described in connection with other forms of workplace violence.⁶ What is unique about these medical incidents is that the frequency of the categories is much different than in other settings. The most common categories in medical facilities were the mentally ill (35%), abusive supervisors (17.5%), disgruntled former patients (15%), personal/domestic disputes (12.5%), and disgruntled students/trainees (10%). Criminals and disgruntled employees were uncommon in health care settings. When *all* cases of workplace violence were considered, however, the most frequent categories were criminals, personal/domestic disputes, and disgruntled employees.

Thus, the motivation for workplace violence in medical facilities is somewhat different than that found in other settings. These motivations include highly personal issues influenced by psychiatric illness, a need for power over or exploitation of others, and a desire to extract revenge for an interpersonal conflict separate from the workplace. The common thread for all of these motivations is that they may not be apparent to supervisory or security personnel in the hospital

or clinic. Standard intervention strategies used to deal with criminals intent on robbery, dissatisfied employees, or disruptive patients may not be effective with these groups.

It should be noted that while the mentally ill constituted the largest group committing violent acts in medical facilities, they were *not* patients being treated at the institution. Rather, they chose their target randomly or based on some delusional belief not readily apparent to others. Once again, the strategies used on inpatient psychiatry units to identify at-risk patients may not be effective with these individuals.

Offenders in medical facilities also display a somewhat different diagnostic pattern when compared to other forms of workplace violence. As noted earlier, the most common primary psychiatric diagnoses in the medical incidents were borderline personality disorder (18.42%), pedophilia (10.53%), and depression (13.16%). Personality disorders represented the most frequent diagnostic group (31.58%), followed by psychosexual disorders (21.05%), affective disorders and psychotic disorders (13.16% each). When all workplace violence was examined, the most common diagnoses were depression (18.6%), antisocial personality (16.4%), and borderline personality disorder (10.94%); the most frequent diagnostic groups were personality disorders (37.64%), affective disorders (20.35%), and substance abuse disorders (17.72%).

Thus, the primary differences in psychopathology among the medical setting offenders are the absence of antisocial personality disorders, the marked increase in psychosexual disorders, and larger numbers of psychotic individuals. What might account for these differences? Three factors must be considered. First, crime statistics indicate that medical facilities are uncommon targets of robbers and other criminals.² In our overall sample of workplace violence, the antisocial personality diagnosis was associated almost entirely with the criminal category. Due to the large number of persons working in most medical facilities, the highly visible nature of most hospitals and clinics, and the frequent presence of security personnel, they are not good targets for robbers whose primary goal is escape. When robberies or muggings do occur, they are most frequently in areas adjacent to the facility, such as poorly lighted parking lots, garages, or side streets.

The second explanation for the diagnostic differences concerns the presence of psychosexual disorders. Meloy has cited the need for power,

Table 6. Characteristics of Non-Patient Violence in Medical Settings

- The violence is usually committed by males (84%) with a mean age of 35.4 years.
- Offenders usually act alone.
- External threats (ie, from outside the workplace) account for 65% of incidents, while internal threats (ie, employees or supervisors) are responsible for 35% of cases.
- Handguns are used in 46% of incidents.
- Excessive interest in weapons is found in 13% of perpetrators.
- Over 94% of offenders have psychiatric diagnoses.
- Personality disorders and psychosexual disorders comprise the largest diagnostic group (31.58% and 21.05%, respectively).
- A completed suicide occurs in 5.26% of cases, suicide attempts in 7.89%, and suicide threats in 31.58% of incidents.
- Alcohol and drug use are found in 21% and 10% of offenders, respectively.
- Warning signals are apparent in 90% of cases.
- Stalking of the victim occurs in 67.5% of cases.
- An average of 0.7 persons are killed per incident, and 2.85 persons are injured per incident.

intimidation, and control in persons who commit sex crimes.¹⁹ For individuals with psychosexual pathology, hospitals and clinics provide relatively easy access to victims. Patients may be seriously ill or disabled, and therefore unable to resist sexual advances. The level of trust that most patients have in health care providers makes it unlikely that they would be suspicious of disguised sexual advances. Likewise, staff work in close proximity, often in stressful situations, where inappropriate, sexual advances may be overlooked or not reported due to fear of retaliation or loss of job. It should be noted that in this study, abusive sexual behavior was equally directed toward both patients and staff.

The third factor has to do with the fact that psychotic persons may be drawn to hospitals and clinics based on psychotic transferences to previous physicians or therapists at other institutions. Medical facilities may also be targeted by psychotic individuals based on grievances or perceived injustices from past treatment. The loss of reality testing characteristic of psychotic states may influence these persons to group all hospitals and clinics together, resulting in a retaliatory attack on a facility even though the individual never received treatment there.

Several other differences exist between workplace violence in medical facilities and other settings. For example, workplace violence is generally associated with the use of firearms (77% of the incidents). In medical incidents, however, firearms were used in only 57% of cases. The use of physical force occurred more often in medical facilities than in other settings (28.57%),

Violence in Medical Facilities

as might be expected from the large number of sexual assaults. Overall, violence in medical settings carried a lower injury and fatality rate than other incidents. Large scale assaults were uncommon, with most incidents directed at only one or two individuals. An excessive interest in weapons among perpetrators was also less common than in other types of workplace violence: 13% in medical incidents compared to 39% overall.

One of the most striking aspects of violence in medical settings is that 90% of cases were associated with clear warning signals. Common indicators included bizarre or unusual behavior, reports of domestic violence, a history of complaints against the perpetrator lodged by patients or staff, and frequent disciplinary actions. The frequency of warning signs implies that many of these incidents could have been prevented if appropriate steps had been taken earlier.

Another important finding is the frequency of stalking in these incidents. Over 67% of medical cases were associated with stalking, compared with 44% in other forms of workplace violence. The presence of stalking should be carefully considered with the other warning signals discussed above. It also has significant implications for hospital security, as discussed below. All of these factors exert a significant impact on management, intervention, and security strategies. These will now be examined in greater detail.

Implications for Hospital and Clinic Security

Unfortunately, no occupational setting is immune from acts of violence. While adequate planning and security is essential in the prevention of violence, medical facilities pose a number of special problems. These include the high volume of traffic commonly found in hospitals and clinics, the need to maintain an open environment to facilitate patient use of medical resources, and the importance of maintaining a therapeutic atmosphere. It is clear that turning hospitals and clinics into "armed fortresses" will have a detrimental effect on both staff and patient morale, and will detract from the quality of care provided.

What can hospitals and clinics do to prevent violence? Danto has examined the unique problems associated with hospital and office security.²⁰ He cites the power with which health care providers are endowed by society as both strengths and liabilities. This power not only increases the expectations of patients and the pub-

lic at large, but also leads to resentment and hostility when expectations are not met. Thus, health care facilities come to be viewed ambivalently by those with violent tendencies.

The development of adequate security measures must be accompanied by careful consideration of five major areas. The first consists of **staff training and education**. The issue of violence must be addressed in order to heighten awareness. Recognition of the warning signals of impending violence is essential. Situations likely to result in violence must be identified and intervention strategies developed. Since residents frequently provide emergency room and nighttime coverage, they should be involved in all training activities. Training should include such areas as anger management, substance abuse, and domestic violence. With the exception of staff on psychiatric units, most health care professionals do not consider violence an occupational hazard. They also tend to experience negative affective responses to threatening situations. In-service training programs are an effective way to deal with these attitudinal issues.

Consultation with security personnel is essential for maintaining a secure therapeutic environment. Hospital security officers should be included in staff training sessions. Large clinics should employ security guards, if they are not already present. All threatening or suspicious incidents must be reported and investigated. Likewise, incidents occurring in small clinics or physicians' offices should be reported immediately to local law enforcement agencies. A close liaison with security personnel or local police is essential to minimize the risk of violence. A specific person, such as the clinic director or office manager, should be identified to develop and maintain this liaison.

Basic security precautions must be employed in all settings. This includes limited access to all clinical areas. Photo identification badges should be worn by all staff and employees. Waiting areas should be physically separated from patient care areas, with a security guard stationed at the interface. In physician offices, the door separating exam rooms from the waiting area should remain locked. Maintaining an alternate exit for all clinical staff is also important. The same precautions are to be taken for billing offices, since they may be the target of disgruntled former patients. A clerk, receptionist, or office manager must be assigned the responsibility of monitoring for suspicious activity in those settings

where security guards are not employed. Finally, a supportive and empathetic environment must be created for staff who may be the victims of domestic violence.

It is imperative that all institutions develop a **crisis management plan**.² Internal and external threats must be assessed and responded to. Essential components of the plan should include designated escape routes for all employees. Code words can be utilized to alert everyone of a potential threat. In those settings where clinicians often work alone in offices or exam rooms, regular check-in times can be easily established to insure that all personnel are safe and accounted for. A resource directory should be housed on-site which includes all important telephone numbers, referral sources, and consultants. Along with this directory, a clearly defined chain of command must be established to guarantee that the proper people are notified in the case of emergency. It should be remembered that crisis situations are usually very chaotic; a preplanned response team can help to overcome this tendency.

Finally, all staff should be familiar with strategies for **defusing potential violence**. Maintaining good relations with staff, patients, and visitors provides a solid foundation for dealing with conflicts. Stress management programs are useful in defusing potential disputes and improving morale. Employee assistance programs are of benefit in the recognition and management of impaired employees. These programs should also be made available to spouses/partners of employees in order to reduce the potential for domestic violence being brought into the hospital. Training in effective communication skills and the management of anger are also of benefit. Recognition of mental illness and substance abuse is also important, particularly for non-psychiatric clinicians.

Summary

Medical facilities are at risk for violent acts, not only from patients but also from the public at large. Most hospitals and clinics are poorly prepared for such events. Attention to the security and management issues described above will minimize the risk of violence. Training and intervention strategies can be easily implemented and are cost-effective when compared to the consequences of a lethal assault. Increased awareness of the problem is essential, coupled with staff training and adequate security measures. Implementation of basic security strategies will facili-

tate staff effectiveness and morale, protect the safety of health care workers, and improve the quality of patient care.

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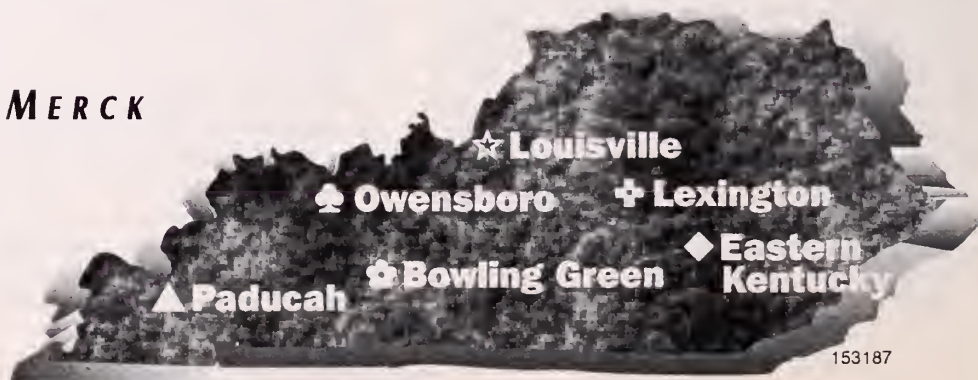


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Wilms' Tumor in an Adult: A Case Report and Review of the Literature

David Butler, MD; John J. Buchino, MD; Baby Jose, MD; Robert D. Lindberg MD; William J. Spanos, Jr, MD; Kristie J. Paris, MD

Wilms' tumor in an adult is extremely rare, with less than 250 cases reported in the world literature. Treatment guidelines for pediatric Wilms' tumor are well established; those for adults are not. This article presents the case of a 19-year-old male diagnosed with Wilms' tumor after complaints of hematuria. He was categorized as Stage IV after nephrectomy and received post-operative radiotherapy and chemotherapy consisting of Vincristine, Adriamycin, and Actinomycin-D. Two years later he was found to have metastases to brain and lungs. He was treated with radiotherapy and bone marrow transplantation, and died of septic shock. The literature regarding Wilms' tumor in adults is reviewed, and current therapy is discussed.

Wilms' tumor is the most common renal malignancy of childhood.¹ It accounts for approximately 5% of all childhood neoplasms, with 350 new cases diagnosed per year in the United States.² These tumors have been studied extensively in children, and treatment parameters and guidelines have been well established. Multimodal therapy utilizing chemotherapy, surgery, and radiation therapy have produced survival results of up to 90% in children.³ Adults (>15 years of age) with Wilms' tumor are relatively rare, with only 223 cases recorded in the world literature from 1878-1990.^{3,5} Wilms' tumors in adults tend to present at a more advanced stage than in children, and stage-for-stage have a poorer prognosis.³ Treatment options in adults are less well-defined. We report a case of Wilms' tumor in an adult, with a review of the literature regarding prognosis, pathology, and treatment.

Case Report

A 19-year-old white man presented in April of

1989 with complaints of intermittent hematuria, and upon physical examination was found to have an abdominal mass. A KUB, IVP, and CT scan of the abdomen showed a left retroperitoneal mass in the area of the kidney confined to Gerota's fascia (Fig 1). Function of the upper pole of the kidney was absent. A renal vein thrombus was present without evidence of extension into the vena cava. An arteriogram revealed a large intrarenal mass pushing the stomach upward and the hilar vessels laterally. Chest x-ray was unremarkable; urinalysis and hematologic parameters were within normal limits.

On April 25, 1989, he underwent left nephrectomy and removal of a left renal vein thrombus. Post-operatively the patient had difficulty maintaining adequate ventilation and was found to have a tumor embolus in the left main pulmonary artery. This was removed, and the remainder of

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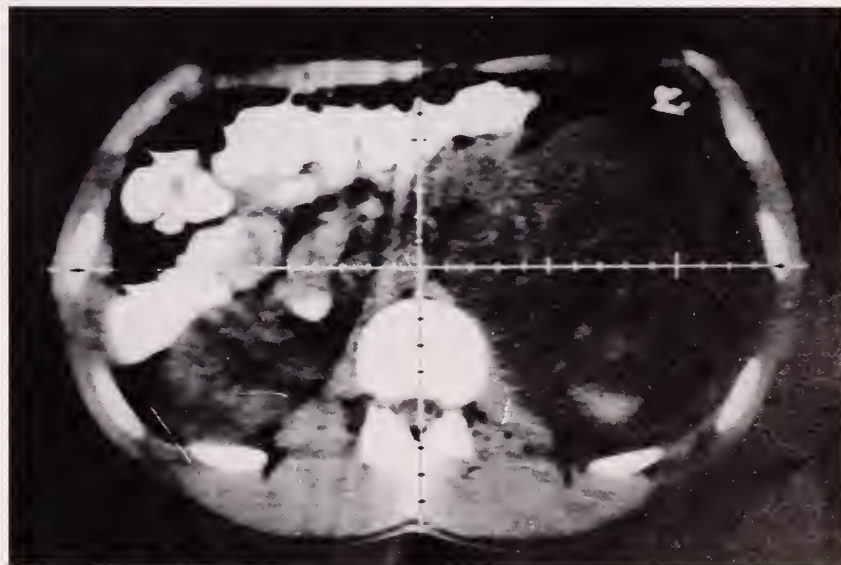


Fig 1 — CT scan of the abdomen showing a large left-sided renal mass.

Wilms' Tumor in an Adult

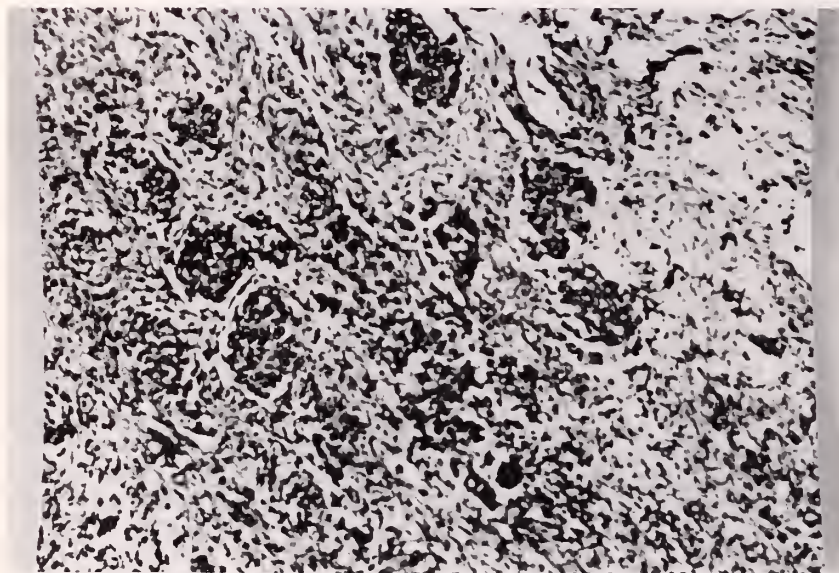


Fig 2 — Low power photomicrograph of tumor showing predominant blastematos nature. Blastemal aggregates give appearance of glomeruloid body formation. (H & E; $\times 60$ power.)

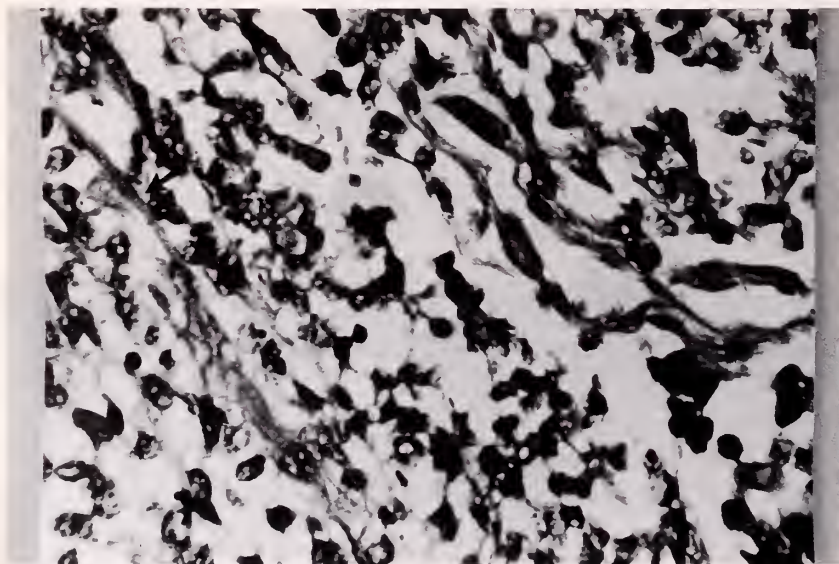


Fig 3 — High power photomicrograph of tumor revealing skeletal muscle differentiation with numerous cross-striations readily apparent (arrows). (H & E; $\times 500$ power.)

the patient's post-operative course was uneventful.

Gross pathologic examination revealed a 1896 gram kidney measuring $24.5 \times 22.8 \times 8.2$ centimeters. A flattened adrenal gland was attached to the upper pole. No gross penetration of the renal capsule by the tumor was noted.

Bisection of the specimen in a sagittal plane demonstrated a 15×13.5 cm tumor occupying the upper pole and mid-portion of the kidney. The tumor was grey, lobulated, and had a bulging cut surface. Large areas of hemorrhage and necrosis were present. The renal vein contained tumor thrombus.

Microscopic examination of the tumor revealed predominantly cells with small, oval hyperchromatic nuclei having scant eosinophilic cytoplasm with indistinct cell borders consistent with blastema of Wilms' tumor (Fig 2). While epithelial elements were not identified, skeletal muscle differentiation was noted in multiple foci (Fig 3). There was no evidence of anaplasia. In addition to the nephrectomy specimen, thromboemboli from the pulmonary vessel were examined and found to be composed of tumor. A diagnosis of favorable histology Wilms' tumor was made. The Wilms' staging criteria for a patient with a tumor pulmonary thromboembolus is not clear. We elected to categorize and treat the patient as a Stage IV. Using the National Wilms' Tumor Study guidelines for Stage IV, the tumor bed received post-operative radiotherapy. From 5/10/89 to 6/20/89, 45 Gy in 25 fractions were delivered in 42 days using AP:PA fields with 18 MV photons. He experienced minimal side effects from treatment (mild nausea and fatigue) and required one transfusion with packed red blood cells toward the end of his treatment due to a hemoglobin of 9.3. Between July and September 1989, he received six cycles of Vincristine, Adriamycin, and Actinomycin-D which were well tolerated except for occasional nausea and vomiting. A bone marrow harvest was done at completion of treatment in case of relapse.

The patient was seen in follow-up and repeat CT studies were normal. In September 1991, he presented to the hospital emergency room complaining of headaches and mental status changes. A CT scan of the brain demonstrated a 6×3 centimeter lobulated enhancing lesion in the left temporoparietal junction with associated edema extending into the left frontal lobe (Fig 4). Chest x-ray revealed a left upper lobe nodule. CT of the chest showed a pulmonary nodule in the left anterior/superior hemithorax measuring 2 centimeters and a small 1 centimeter pleural density in the right hemithorax consistent with metastatic disease. On 9/9/91, he underwent a left frontal temporoparietal craniotomy with complete resection of the brain lesion. Microscopic examination revealed metastatic tumor identical to that seen

in the nephrectomy specimen.

He underwent post-operative whole brain radiotherapy from 10/21/91 through 11/12/91, receiving 30 Gy in 12 fractions with 6 MV photons, followed by a boost of 7.5 Gy in three fractions to the tumor bed for a total tumor dose of 37.5 Gy. Two days of treatment were missed due to nausea, but otherwise radiotherapy was well tolerated.

In January 1992, the patient was scheduled to undergo autologous bone marrow transplantation for treatment of his pulmonary metastases. Two days prior to admission, he began to experience symptoms of nausea, vomiting, and shortness of breath associated with left upper quadrant abdominal pain. No etiology for his complaint was discovered. He was admitted to the hospital and underwent bone marrow transplant on 1/20/92. Approximately 3 weeks later, the patient's white blood counts recovered sufficiently that he was transferred from the bone marrow unit to a general medical ward. Shortly thereafter he complained of intense abdominal pains. Work-up revealed elevated liver function tests and a dilated gallbladder with hypokinetic walls on ultrasound. HIDA scan was consistent with acalculous cholecystitis. On 2/19/92, the patient became hypotensive and unresponsive. He was resuscitated and an emergent cholecystectomy was performed that evening. Two days later the patient manifested signs and symptoms of septic shock. His condition deteriorated and he was pronounced dead later that day on 2/21/92. An autopsy was not performed due to family request.

Discussion

The classic histology of Wilms' tumor is that of a triphasic embryonal neoplasm containing varying amounts of blastema, stroma, and epithelial cells forming abortive tubular or glomerular structures.⁶ However, not all of these components need be present in order to make the diagnosis of Wilms' tumor.

There are a number of different staging classifications, but the system most widely utilized is that of the National Wilms' Tumor Study Group. This staging system is based on surgical and pathological findings and was used in our case.

The incidence of nephroblastoma in adults is low. Despite over 200 cases having been reported in the literature, a review by Kilton⁷ in 1980 found only 35 cases which fulfilled the criteria of the National Library of Medicine in Bethesda,

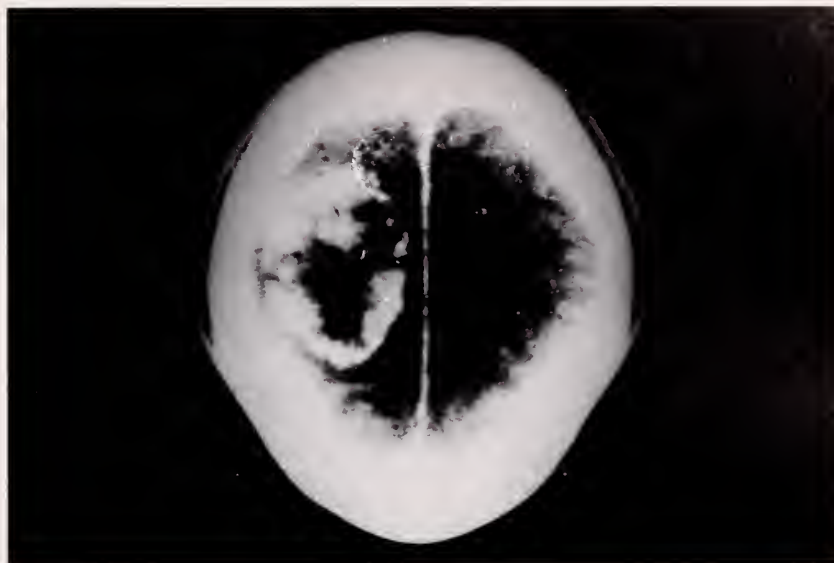


Fig 4 — CT scan of the brain showing metastatic adult Wilms' tumor to the left temporo-parietal region.

Maryland. Since that time, a number of other series have been published that meet these standards. Of the papers referenced in this article, only those of Mehta and Kumar do not address the specific pathology of their cases in a manner which would fall within the accepted criteria of the National Library of Medicine. These criteria are as follows: (1) primary renal neoplasm, (2) primitive blastematos spindle or round cell component, (3) formation of abortive or embryonal tubular or glomeruloid structures, (4) no area of tumor diagnostic of hypernephroma, (5) pictorial confirmation of histology, and (6) age >15 years. Our case meets these criteria.

Several studies have reported that adults with Wilms' tumor have a poorer prognosis stage for stage compared to children,^{3, 7, 8, 9} with Culp and Hartman, and Foot et al reporting an overall survival of 18% and 27%, respectively. This is in contrast to a study published by Arrigo et al¹⁰ based on adults with Wilms' tumors entered into the NWTS registry in which survival was 67% at 3 years. The techniques of treatment in these patients were formulated prior to the current parameters of the NWTS which uses conventional multiagent chemotherapy as a routine. Kilton's study⁷ of 25 patients demonstrated a survival of 44% at 3 years, while Byrd's review³ reported a 2 and 3 year survival of 54% and 24%. This is in contrast to the data from the NWTS, which has an overall mortality rate of 10% for pediatric Wilms' tumors¹¹ (Table 1).

Different theories have been proposed as to the reason for this difference in survival between adults and children with Wilms' tumors. Amongst

Wilms' Tumor in an Adult

Table 1

Author	M/F	#PTS	Age Range (yrs)	Mean Age (yrs)	Stage	Actuarial Survival	Survival	Disease Free Survival	Anaplasia
Huser	8/3	11	21-67	32	I 9% II 45% III 36% IV 9%	—	18% @30 ma.	—	0/11
Byrd	7/17 7 Unkn.	31	17-63	29	I 29% II 16% III 19% IV 29% Unkn. 7%	24% 3 yr	I & II 48% III & IV 11%	—	—
Mehta	12/11	23	17-84	23	I 13% II 5% III 39% IV 39% Unkn. 4%	—	9/21 (43%)* @ 19 months I & II 2/3 III 2/6 IV 1/7	— *I & II 1/4 III — Nat repeated IV 1/6	—
Kilton	20/15	25	—	40	I 28% II 8.5% II 8.5% III 17% IV 14% Unkn. 6.5%	—	I & II 12/14 (86%) @ 18 mas. III 2/6 @ 18 mas. IV — No survivors over 5 mas.	11/25 (44%) @ 3 yr	—
Arriga	—	27	16-74	29	I 22% II 18.5% III 15% IV 41% V 3.5%	—	67% @ 3 yrs	—	4/27

Unkn. = Unknown

F/U = Follow-up

O.S. = Overall Survival

DFS = Disease Free Survival

* = 2 Patients Unknown

children, stage, histology, and age have been found to be of prognostic importance, although age has become less significant due to modern chemotherapeutic techniques.¹¹⁻¹³ The percentage of adults who present with high stage disease is greater than that of children. In Mehta's review, greater than 80% of 23 cases presented in stage III and IV⁵ compared to 44% in Kilton's,⁷ and 54% in Byrd's.³ However, even when adjustments are made for stage, survival in adults is worse³ (Table 2).

Huser et al investigated 11 adults with Wilms' tumor with regards to pathologic and histologic prognostic indicators. Only 2/11 patients were long-term survivors, and both of these patients were those with tumors of a predominantly blastematos component. Mitotic rate in the two long-

term survivors was 5-10 per high power field, compared to a mean of 34.8 in the patient dying of disease.⁶ Jereb and Sandstedt, on the other hand, did not find mitotic rate to be a useful indicator of prognosis in their analysis of patients.¹⁴

Anaplastic histology has been strictly defined by NWTS and is a significant histologic correlate of unfavorable outcome for Wilms' tumor in children.^{13,15} Anaplastic histology has also been investigated as to prognostic significance in adult Wilms' tumors. Prestidge reported 4 of 5 cases of Wilms' tumors in adults treated at Stanford from 1967-1987 as having unfavorable/anaplastic histology.¹⁶ This contrasts sharply with an incidence of 11.5% in children reported in NWTS I and II.¹⁷ Children with anaplastic tumors are usually older, have a greater number of lymph node metastases,

and are less responsive to treatment. Byrd's review did not address the presence of anaplasia, nor did that of Kilton.⁷ Huser's study of 11 patients had no patients with anaplasia,⁶ while Arrigo had 4 of 27 patients with anaplastic features. All four of these patients presented with Stage IV disease.¹⁰

The natural history of Wilms' tumor in adults appears to be different from that in children.^{3, 18-21} Besides a more advanced stage at diagnosis and poorer response to treatment than in children, the adults appear to be at risk for relapse for a much greater time period.^{3, 4, 16} Most children who are free of disease at 2 years from completion of treatment have very little likelihood of relapse.²² In adults, there is continued fall-off from the survival curve at 2 years, and in Byrd's series this continues up to 8 years.^{3, 16, 18} Lymph node involvement and sites of metastatic disease are usually similar to that observed in children.^{18, 23} Our patient is exceptional in that he experienced a metastatic lesion to the brain. Brain metastases are generally seen in patients with rhabdoid and clear cell sarcoma histology, but subsequent pathologic review and consultation regarding the histology of this case confirmed it to be true Wilms' tumor without rhabdoid or clear cell features.

Treatment of Wilms' tumor in adults continues to remain controversial. While there are no defined guidelines pertaining to the treatment of this disease, a number of recommendations are presented in the literature. Kilton⁷ and Byrd³ both recommend aggressive surgery, chemotherapy, and radiotherapy based on children's Wilms' tumor protocols. Byrd suggests radical nephrectomy, post-operative XRT for all stages to 45 Gy, and 3 drug or greater multiagent chemotherapy. Kilton also suggests surgery for diagnosis, debulking, and treatment for all stages, with local post-operative XRT in the range of 35-40 Gy. Chemotherapy recommendations differ from Byrd's in that Kilton recommends only Vincristine and Actinomycin D, even though there is no definitive evidence that Actinomycin D works in adults in the same manner as in children. Kumar⁴ and Arrigo¹⁰ each recommend graded treatment based on the stage grouping at initial presentation, except in the case of anaplastic histology which Arrigo maintains remains unclear. For those patients with favorable histology, Stage I would receive surgery and 6 months of VCR/AMD without XRT. Stage II would receive surgery and post-op radiotherapy to approximately 20 Gy, and then 15 months of AMD/CVR/ADR, as would Stages III and IV. Pulmonary metastases would receive 12-

Table 2

Stage	Peds*	Kilton	Byrd	Huser**	Mehta#
I	90		5/9	0/1	3/3
II	80	12/14##	4/5	1/4	0/1
III	75	2/6	1/6	1/4	2/6
IV	70	0/5	1/9	0/1	1/7

* Data from NWTS III.

** 1 Pt. with less than 1 month F/U not included.

17 pts eval. B/C 3 lost to F/U, & 3 with F/U < 8 mos.

I & II Combined

15 Gy to both lungs, 20 Gy to the whole liver if involved, and 30 Gy to other affected sites of disease. Arrigo reported a 3-year actuarial survival of 79% for Stages I to IV favorable histology, and 67% with inclusion of anaplastic histologies.¹⁰ This is still poorer than that obtained with children, but a marked improvement over the above previously reported cases.

Our treatment parameters for Stages II-IV FH Wilms' would include surgery, post-operative XRT, and 3-drug chemotherapy, but we would carry our XRT dose to 40-45 Gy as suggested by Byrd and Kilton. Although there are no definitive data concerning a need for greater doses of XRT in adults with Wilms' tumor as compared to children, we treated our patient to higher dose based on the fact that the natural history of Wilms' in adults is different,¹⁸⁻²¹ the stage at diagnosis is more advanced,^{3, 5, 6} and response to treatment is poorer than in children.³ Anaplastic adult Wilms' tumor should be treated in a more aggressive manner than that advocated for favorable histology Wilms' tumor. Mehta suggests prophylactic pulmonary XRT to both lungs for any Stage II/IV disease due to 12/14 of their analyzed cases developing pulmonary metastases. More studies are needed to define the exact course of management in this disease based on the different prognostic factors.

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Wilms' Tumor in an Adult

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Tuberculous Lymphadenitis in the Adult

Catherine L. Sewell, MD; Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD; Jay B. Mehta, MD

A relative increase in the percentage of patients with extrapulmonary sites of infection has been documented nationally (Fig 1). This percentage increase can partly be explained by the constant number of patients with extrapulmonary tuberculosis but a continued decline in total and pulmonary cases. There is also evidence that the actual number of patients with extrapulmonary tuberculosis is increasing, especially in populations with immunodeficiency.¹ The likelihood that the primary care physician may encounter a nonpulmonary manifestation of tuberculosis is therefore increasing. Although the most common form of extrapulmonary tuberculosis involves the pleura, lymphatic tuberculosis is the second most common extrapulmonary expression and is often more difficult to recognize.

Case Report

A 41-year-old white male presented with swelling in his neck of 6 weeks duration. He had tested positive to a PPD skin test 2 years earlier with 20 mm of induration. He was not compliant with antituberculous prophylaxis. The swelling in his neck was tender and failed to respond to outpatient treatment with oral antibiotics. Over the last 6 weeks the swelling had increased. The patient had intermittent night sweats and a weight loss of 16 pounds. He denied shortness of breath, fever, dysphagia, nausea, vomiting, or rashes.

Past history was important for cigarette smoking for 20 years and daily alcohol consumption. He admitted to intravenous drug use 6 years prior to this admission. He had been a resident of Salvation Army facilities and homeless shelters. He denied any homosexual encounters and had a monogamous relationship with his girl friend of 2 years.

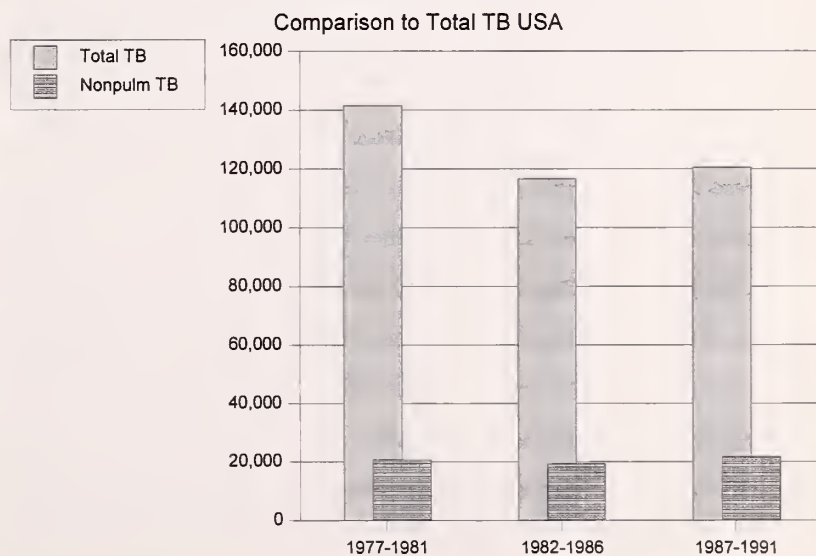
The patient was normally developed. He was in no distress with normal vital signs. Examination of the head, eyes, ears, and throat was normal. There were multiple lymph nodes present bilaterally, involving the anterior and posterior cervical

chains. There was tenderness and confluence of the nodes in the right anterior cervical distribution. No ulcers or drainage of the lymph nodes could be found. The remainder of the physical examination was unremarkable.

The patient's hemogram, white cell count, electrolytes, renal and liver indices, and urinalysis were normal. Standard chest radiographs were unremarkable. Computerized tomography of the neck confirmed multiple lymph nodes with areas of central necrosis and cavitation in the right anterior cervical region. A fine needle aspiration (FNA) was performed and acid fast bacilli (AFB) were recovered. Identification of *Mycobacterium tuberculosis* was confirmed by PCR and culture. Induced sputum was smear and culture negative. The patient tested positive for the human immunodeficiency virus (HIV) by serology and by Western Blot. The patient was started on 4 drug antituberculous treatment with good clinical response.

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Extrapulmonary TB in USA



Tuberculous Lymphadenitis in the Adult

Discussion

Peripheral lymphadenopathy is the most common expression of lymphatic tuberculosis. The sites most frequently affected are the cervical and supraclavicular lymph nodes, followed by the inguinal and axillary chains. In 80% of patients with tuberculous lymphadenitis, only a single group of nodes is involved. These nodes are tender during enlargement, but eventually soften, coalesce and become painless. Matting of the nodes is a common phenomenon secondary to periadenitis and is thought to be an important diagnostic clue in recognizing tuberculous lymphadenitis. Sloughing and drainage occurs in a minority of patients.²

Tuberculous lymphadenitis occurs more frequently in the second and third decades of life and affects females slightly more often than males. The patient usually presents with painless cervical mass. On presentation to the health care worker, the average size of the mass is 2.8 cm with a range of 1.2 to 5.5 cm. On examination this mass is typically made up of multiple cervical lymph nodes. Constitutional symptoms such as weight loss, fever, or malaise are typically absent in patients living in developed countries.³ The presence of additional symptoms should suggest the presence of a combined disease as seen in our patient.

Approximately 80% of patients with lymphatic tuberculosis will have a significant reaction to the standard strength (5 IU) of PPD. Clinical or radiographic evidence of tuberculosis involving other organs, including the lungs, is present in only 20% of patients. It is generally assumed that the extrapulmonary lymph nodes are seeded during the initial unopposed lymphohematogenous spread of the bacillus. The limited expression of concurrent pulmonary tuberculosis, however, has prompted investigators to hypothesize that the tonsils, adenoids, and Waldeyer's ring may provide the portal of entry for inhaled bacilli. These bacilli impact on the pharyngeal wall, leading to upper cervical node involvement.³ Although this avenue of infection is plausible, it is equally likely that lymphatic tuberculosis can remain dormant for many years after the original infection with *M tuberculosis* and express itself after successful handling of the bacilli in the lung.

Computerized tomography has been used to distinguish cervical tuberculous lymphadenitis from other causes of lymphadenopathy. The scan characteristically shows a pattern of central low

density with peripheral rim enhancement that tends to be thick and irregular, unlike that seen with malignant lymphadenopathy. Identification of necrosis or cavitation is extremely helpful.⁴

The involved lymph node is generally enlarged and approachable for biopsy. FNA with cytologic examination of the specimen is the initial diagnostic procedure. FNA is less expensive and less invasive than excisional node biopsy, a procedure that usually requires hospitalization. Caseous necrosis and epithelioid cells are the most characteristic features in the aspirated smears of tuberculous lymphadenitis. Acid-fast bacilli are recognized 45% of the time and cultures are positive for *M tuberculosis* in only 35% to 60% of specimens.⁵

There are limitations to the diagnostic effectiveness of FNA in the diagnosis of tuberculous lymphadenopathy. The cytologic findings can be similar to other forms of granulomatous lymphadenitis. A diagnostic distinction is not always possible unless AFB can be demonstrated or a markedly significant reaction to PPD has been documented. Potential false negative cases may result from the limited yield of the cultured specimen.⁶

Histologic and bacteriologic studies on nodes removed surgically prove to be the most reliable diagnostic procedure. The high accuracy of diagnosis with excisional biopsy relates to the fact that the entire node is typically affected at the time that the patient presents. Such a node provides ample tissue for analysis. Excisional biopsy, however, is generally reserved for patients with a nondiagnostic FNA. Injury to adjacent structures is a hazard of surgical dissection in an area where fusion of nodes makes identification of tissue planes difficult. Trauma to the spinal accessory nerve, phrenic nerve, mandibular branch of the facial nerve, the brachial plexus and the internal jugular vein have been reported with diagnostic excisional node biopsy.⁷

Culture confirmation of *M tuberculosis* should be attempted since cervical lymphadenitis is five times more likely to be due to atypical mycobacteria in the United States. Although conclusive, such mycobacterial confirmation is not always possible. Multiple culture techniques using Lowenstein-Jensen medium and liquid Kirchner's medium for 12 weeks allow positive cultures in 68% of cases.⁸ A negative culture does not exclude the diagnosis of tuberculosis, since all enlarged lymph nodes do not necessarily contain live bacilli.⁹ Fortunately, the literature indicates

that cervical adenitis due to atypical mycobacterium is almost exclusively a disease of children. This allows the histopathologic aspects of tuberculous lymphadenitis from biopsy material to be diagnostically helpful in adults.⁹

The use of commercial serologic testing for the presence of mycobacterial disease has been successfully employed, but specificity remains poor.¹⁰ More commonly, a rapid diagnosis of tuberculous lymphadenitis is confirmed by amplification of mycobacterial DNA through polymerase chain reaction (PCR). Demonstrating specific DNA fragments in lymph node biopsies allows prompt diagnosis and early treatment. In fact, a comparison of acid fast stains and PCR suggests that the PCR-method is more powerful and more sensitive.¹¹ The application of PCR technology is expected to increase the diagnostic accuracy of lymph node FNA.

The treatment of extrapulmonary tuberculosis involves the same bactericidal agents used in treating pure pulmonary tuberculosis. The bacterial population is much smaller in extrapulmonary tuberculosis than in pulmonary disease. Agents such as isoniazid (INH), rifampin (RIF), and pyrazinamide (PZA) penetrate well into tissues and attain sufficient levels in lymph nodes to kill the organisms.¹²

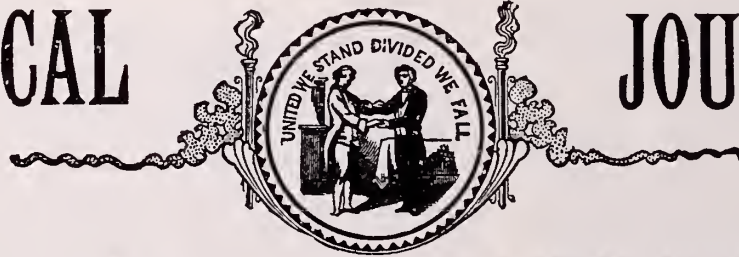
Response to treatment is completely favorable in about 70% of cases. The clinician needs to recognize that tuberculous lymph nodes can transiently enlarge during therapy. This does not imply relapse or treatment failure, but is attributed to cellular reaction to the by-products of mycobacterial disintegration. After successful treatment, approximately 10% of patients are left with residual nodes larger than 10 mm. Initial lymph node excision does not seem to improve the outcome and is reserved for diagnostic purposes and for the minority of patients with discomfort due to large nodes that are tense, fluctuant, or draining.¹³

The recognition of extrapulmonary tuberculous lymphadenitis has assumed more importance since the AIDS epidemic. There is evidence that the AIDS patient is more likely to have disseminated and extrapulmonary manifestations of tuberculosis. The clinician must keep a strong index of suspicion for the co-existence of HIV illness when tuberculous adenopathy is confirmed.¹

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CONTENTS AND DIGEST.

EDITORIALS.

- THE KENTUCKY MEDICAL LAW:** Kentucky one of the few States freed from quackery. Conditions existing before passage of law. More efficient entrance requirements for medical students. Accomplished by a united profession. What remains to be done 1
- ABOUT THE JOURNAL:** Every member is an owner of THE JOURNAL. Rules governing admission to advertising pages to be more stringent. Every cent of income from the JOURNAL to be expended on the JOURNAL. Importance of helping our advertisers.... 2
- SPECIALTY MEN:** A simple plan for recognizing the bad ones..... 3

- ANNUAL DUES:** Your County and State dues should be paid to-day. Help your Secretary 3
- SOME ADVERTISEMENTS:** The importance of using pure whiskey in the small number of cases where its use is necessary. 3
- PHYSICIANS AND PROPRIETARY DISINFECTANTS:** Ease with which doctors may be duped. Analysis of a new method. The importance of thorough disinfection..... 9

SCIENTIFIC EDITORIALS

- MASTOID SURGERY:** The radical and simple procedures differentiated. Object of radical operation. Statistics. Indications..... 4
- Contents Continued on Page XI.

To Our Readers

Please consider our newest offering in this Journal which will be a periodic retrospective of KMA JOURNAL articles from 50, 75, and 100 years ago. Our intent is to provide an informative and amusing review of our predecessor's follies and foibles as well as their wisdom and contributions. Certainly no generation possesses a monopoly on insight and knowledge; hopefully, those who inherit our medical heritage will look back upon our current endeavors with favor and tolerance. We invite your commentary.

Respectfully

Jaroslav P. Stulc, MD, FACS, FICS

Medicine . . .

. . . 100 Years Ago

SPECIALTY MEN.

Almost every day some engaging looking man, dressed like a bank president, and as polite as Punch, comes into each doctor's office to demonstrate to him the virtues of diluted wine at high prices as a food in wasting diseases or a new specific for headache and other aches at so much per ache. Most of these men are fakirs, pure and simple. Some of them represent honest houses,

but they all look alike. One of our best county societies has adopted a good plan for ridding their members of the bad class and ask us to recommend its general use by the profession. Ask your next visitor who wants to sell you something if his wares are advertised in your State Journal. If they are they are reliable as nothing else is accepted. Our friends in Campbell-Kenton coun-

ties say this plan is a splendid one to get rid of traveling pests.

We can say to the profession that the Council rejects several advertisements for each one it accepts. We would like to hear from other societies which try this plan.

— *The Journal*, February 1907

. . . 75 Years Ago

TESTICULAR TRANSPLANTATION FROM APES TO MAN WITH HISTOLOGICAL FINDINGS.

BY MAX THOREK, Chicago.

In this preliminary report I wish to refer to some personal experimental and clinical work in which I have succeeded in transplanting testicles from apes to man and vascularization with histological verification of the taking of such grafts.

Judged by the prominence given by the lay press to this subject it is one that is of high interest to people at

large. And it is desirable that practitioners in general should have clear ideas of the great surgical condition of the question as very erroneous opinions have been propagated regarding it. Although much has been written and much more surmised regarding the actual effects of such transplantations, yet as a matter of fact there are but few cases of human testicular transplanta-

tion on record which have been followed by any durable degree of success.

We have but few examples in medical literature which show that the vascularization of such grafts was clearly and unquestionably proved.

— *The Journal*, October 1922

. . . 50 Years Ago

STREPTOMYCIN IN THE TREATMENT OF URINARY TRACT INFECTIONS

W. V. PIERCE, M.D., Covington

No single perfect therapeutic agent has yet been found for the treatment of all infections in the urinary tract. It has not been many years since the only drug of any real value which was available was methenamine.

The introduction of the sulfonamide drugs further increased the therapeutic armamentarium of the medical profession, so that most urinary tract infec-

tions could now be controlled, either by the sulfonamides or by mandelic acid.

Still more recently, another group of therapeutic agents has been discovered, for which the term "antibiotics" has been proposed; these are antibacterial substances of microbial origin. The two most important of these are penicillin, which is derived from a mold, and

streptomycin, which is obtained from a soil actinomycetes.

Many patients have received fairly large doses daily over periods of several months without serious ill effects.

Read before the Kentucky State Medical Association, Paducah, September 30, October 1, 2, 3, 1946.

— *The Journal*, January 1947

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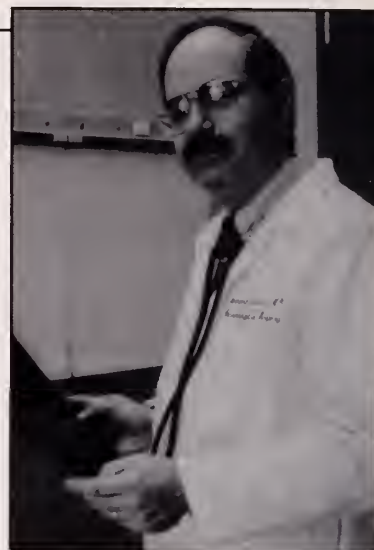
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Before the Plateau

I didn't see the forsythia bloom last year. One day I was anxiously anticipating the joyous explosion of the golden buds, and the next time I looked they were green. It was as though spring was taunting me, reminding me of its fleeting beauty, reminding me that it would not wait until I could fit it in.

The comforting thing is that the forsythia will again bloom. But what about the finite things we miss? The things that won't come around again? Oh, we of delayed gratification, always putting our lives off until tomorrow, until we have time, until we finally get organized, until things slow down, until and after ad nauseum and ad infinitum.

Because of the importance of our work, we have sacrificed, scrambled, apologized, and rearranged. We have been blessed with a capacity to help and people who entrust to us their care. We take a pivotal role in the lives of many, and although someone else could do the job, our patients have requested and entrusted us, and therefore we cannot let them down. So, we make choices. We make inclusions, and we make exclusions. We finish the week exhausted and spent, badly in need of recharging, amazed that yet another week has gone by and still there are so many things left unaccomplished and

undone. But, these are personal things, family things, and they just can't be as important.

The dissonance that develops in our lives is based on this false assumption. Personal and family needs seem less pressing, less urgent, but only when viewed in one dimension, from one perspective. True to our natures, we physicians continue to delay self-gratification just as we did simply to survive medical school and residency. Our patients may or may not care if we have a stable and happy family, if we have stress release and time for physical exercise, if we have a spiritual outlet and good friends to share our lives, but we must care. We must be integral in all parts of our lives, not just our careers. We must find that place where we respond enough to meet the goals we have set, but not respond so much that we subtract from our other goals. This can best be done by living each part of our life on the curve where to do more is to do less, and to do less is to do less. Consider the Starling curve.

All apologies to those true physiologists among you and to Starling himself for this bastardization of the principle, but it strikes me that once you have attained maximum output with a certain input, to do more, to strive harder is to get less,

because each erg of work in increases your output but a miniscule amount, and ultimately not at all. A successful spot on the curve, then, is that place right before the plateau. A successful life might be thought of as intersecting curves in a multi-dimensional fashion with each locus being right before that plateau.

When you say 'yes' to one thing you are saying 'no' to another. If you advance on the career curve, you may simultaneously slip on the family curve. Balance is the essential, just as it is in a high performance engine with a balance of energy out and energy in. This is not a plea against activism and involvement, but a reminder to include those curves which have a weaker representation, ie, our families, our personal interests, our physical health. It is also a reminder to re-value our communities, our schools, our hearts, and our souls.

A truly balanced life is a blend, a dynamic place before Starling's plateau, multi-dimensional and multifaceted, a braid of all the skeins of our being, not just some, woven into a tapestry which is our life. A truly balanced life is a reflection of all that we have to offer and all that we are, which is much more than just our career.

Kimberly A. Alumbaugh, MD

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Aroona Dave

KMAA President 1997-98

Following is the Inaugural Address presented April 17 by Aroona Dave, Madisonville, as she assumed the presidency of the Kentucky Medical Association Alliance.

My story of the involvement with the Medical Alliance for the past many years really begins at home with my family. The story began when two extraordinary ladies, my late mother and late sister-in-law, may God rest their souls, taught me the importance of perseverance, responsibility, dignity, honesty, caring, and self-discipline. I am here today because of three reasons: My dearest true friend — a rock of Gibraltar, my husband Uday, and my two wonderful children, our daughter Manisha Dave Blair, who is my teacher, and our son Nishu Dave, an advisor to me. My husband and my children always encouraged me to stay involved and never to get disheartened. Sometimes my children were at the babysitter. They had to have TV dinners and fast foods whilst I was away being a professional volunteer for the Alliance.

My story begins at our home at the dinner table with our children, nieces, nephews, uncles, and aunts. They ask me "what do you do in the Medical Alliance?" I tell them, as I do you, Kentucky Medical Association Alliance is here to HELP — Meeting community Health needs, Education Research Foundation, Legislation and People. People like you and me, our members, help you to meet

community Health needs raising funds for the Medical Education and Research Foundation, developing leaders and advocating for sound health and medical Legislation. Our focus is to recruit and retain active, motivated and interested members: Career spouses, male spouses, faculty member spouses. We shall actively reach out to all those in the unorganized counties as well.

Individuals in our organization taking their responsibility seriously. The volunteers working tireless hours for "SAVE," Stop America's Violence Everywhere. This is the focus of American Medical Association Alliance.

We should try to work in partnership with others who share similar goals — for instance, having comprehensive school health education in the curriculum of the schools.

We shall work with Kentucky Medical Association to educate the families about the health hazards of smoking, alcohol, and drug abuse. We shall try to influence the irresponsible behavior of child abuse/spousal abuse. We shall work on prevention of sexually transmitted diseases and AIDS.

The donations to the American Medical Association Education Research Foundation AMA-ERF is more than just charitable contributions. They are the legacy from our generation of the medical profession to the next. The quality of medical care and of its practitioners depends on the Medical Alliance's



Aroona Dave

"To follow all those who came before me and what they were trying to accomplish is an honor and an humbling experience; but never forget, as my story merges with yours and becomes our story, that we are caring physicians' spouses, partners in progress for quality health care."

continued support of medical schools through gifts to the foundation.

It takes teamwork between county, state, and national leaders to inform and educate on the issues that directly affect our spouses and the method of health care delivery. Having a day at the Capitol, the educational forums, and activating the Grass Roots Movements through phone-bank, letters, legislative alerts, etc, about the legislative issues are some of the tools we should put to use. County and State Legislative Call-In Day put us directly in contact with our legislators. A network of all three levels does bring results.

My story continues with people. People are the members like you and me. Members are the lifeline of the organization. The challenge for us is to have the moral courage to reach out to the prospective members — active, motivated, and interested when we try to recruit a new member and to retain one. It is everyone's responsibility to list the benefits of the Alliance Membership at all three levels — county, state, and national. We shall try to meet the needs of the members. They join not because of **"who we are,"** but because of **"what we do."**

This is your organization and you are going to tell **our** story. To get participation, we have to work on conveying that this organization belongs to the members. We shall constantly place every member in the foreground of the projects, activities, and decision making process. We all know the **old story** that the easiest way to motivate a member is to point out the personal gain she/he will

"You, the volunteers, are the most valued and special people. Volunteerism is something to treasure and pass the legacy to the next generation. Let us not impose any limits on ourselves. We shall be proactive. If you demand the best, you get the best."

receive through participation. Communication is one of the keys to the success of any organization. It is a two way street — listening, as well as talking to the members. You are the leaders who will help develop other leaders.

Our story needs to be told over and over again in many different ways as to what Alliance's plans are now and what will be in the future. To emphasize if Alliance has worked for you in the past, the time has come now if you can work towards increasing the membership, get people involved in Alliance's focus for the next few years, Stop America's Violence Everywhere "SAVE," and we shall try to inform the County Medical Societies about our mission. We steadfastly believe in our spouses' medical profession and the health care our physicians are giving. Let us spread the word.

You, the volunteers, are the most valued and special people. Volunteerism is something to treasure and pass the legacy to the next generation. Let us not impose any limits on ourselves. We shall be proactive. If you demand the best, you get the best. These are very challenging times we are living in. It is time to be supportive and be compassionate to each other. You are in a position to be able to motivate people to really make a difference.

To follow all those who came before me and what they were trying to accomplish is an honor and an humbling experience; but never forget, as my story merges with yours and becomes **our story, that we are caring physicians' spouses, partners in progress for quality health care.**

Looking at the state of the Alliance, I feel that ample work has been done already, but we do have to go one step further to take us into the next millennium. As I have listened and talked with many of you, I feel confident that we will be shapers of the events, not the observers. We may not have shared the past, but we can share a common future — the future of today's families living safer and healthier lives across the Commonwealth of Kentucky and the Nation.



Aroona Dave
KMAA President

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 4965 US Hwy 42, Ste 2000, Louisville, KY 40222-6301

Deadline for receiving nominations is July 15.

KMA Membership at UK

The Kentucky Medical Association is pleased to report the addition of some 200+ new Active members from the faculty physicians of the University of Kentucky College of Medicine. Due to the strong commitment to organized medicine by Dean Emery Wilson, MD, and the UK Medical Center, a goal has been set this year for 100% participation from the UK physicians.

Along these lines, the KMA Board of Trustees at its December 1996 meeting appointed an Ad Hoc Committee on Faculty Membership to identify, discuss and recommend KMA policy on issues of specific concern to academic physicians to enhance membership at all levels of organized medicine. Chaired by Preston P Nunnelley, MD, Lexington, the committee is composed of representatives from both UK and UL medical schools, and has met on two occasions to address special programs for this important membership group.

KMA is pleased to welcome the following new members from the University of Kentucky, elected to membership by the Fayette County Medical Society on March 11, 1997:

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James G Carr MD
Marty S Clayman MD
George W Colclough MD
Deborah J Cornish MD
Rebecca E Dalmeida MD
Gail B Hajjar MD
Scott W Hardigree MD
Eugene Andrew Hessel II MD
Michael Isley MD
Karl A Kroeker MD
Richard Lock MD
S Jayne Miller MD
Eddie L Owens MD
Rosalind M Ritchie MD
Gregory L Rose MD
Christopher M Scheib MD
Mark E Shockley MD
Paul A Sloan MD
Stephanie J Smith MD
David W Wendel MD
Janet M White MD
Michael L Whitworth MD

Department of Diagnostic Radiology

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Gary R Conrad MD
Andrew M Fried MD
Charles M Kenney III MD
Joseph G King MD
Vesna M Kriss MD
Charles Lee MD
Fang Kum Loh MD
Edward B Moody MD
Marta Pfutzner-Kacki MD

Gayle S Storey MD
James M Strottmann MD
William J Vanarthos MD
John H Woodring MD

Department of Emergency Medicine

Julia E Martin MD
Charles K Stone MD
Sharon E Wells MD
William F Young Jr MD

Department of Family Practice

Suzanne M Blake DO
Wanda C Gonsalves MD
Francis P Kohrs MD
Alan J Maxwell MD
Richard A Neill MD
Elaine L Reed MD
Alan S Wrightson MD

Department of General Surgery

Thomas D Johnston MD

Department of Cardiothoracic Surgery

Timothy W Mullett MD
Juan A Sanchez MD
Julie A Swain MD

Department of Internal Medicine

Cardiology
Craig A Chasen MD
Andrew M Cross Jr MD
Chien S Kuo MD
Roger M Mills Jr MD
James E Muller MD

Peter M Sapin MD
Mikel D Smith MD

Dermatology

Robert H Schosser MD
Margaret H Terhune MD

Gastroenterology

Daniell B Hill MD
David H Van Thiel MD

Hematology & Oncology

Michael A Doukas MD
Roger A Fleischman MD
Kenneth A Foon MD
Timothy C Meeker MD

Infectious Diseases

Martin E Evans MD
Richard N Greenberg MD
Malkanthe I McCormick MD
Robert C Noble MD
Claire Pomeroy MD

Nephrology

Robert M Friedler MD
Thomas H Waid MD

Pulmonary Medicine

Rolando Berger MD
Nausherwan K Burki MD
Dennis E Doherty MD
Richard S Morehead MD
Peter E Morris MD

Takes Dramatic Leap

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James W Anderson MD
Mary M Burke MD
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PEOPLE

Scott B. Scutchfield, MD, a Danville orthopaedic surgeon, has been reelected to the board of directors of the American Academy of Orthopaedic Surgeons. Active in the Academy, Dr Scutchfield is chairman-elect of the Board of Councilors and has served as Kentucky's representative since 1993. He has been the Kentucky Orthopaedic Political Action Committee Chairman since 1994 and is a regional representative for the Orthopaedic Research and Education Foundation. Dr Scutchfield is a past member of the KMA Board of Trustees and is presently on the executive committee of the Kentucky Orthopaedic Association, where he served as president from 1989-91. He is in private practice and is also an associate clinical professor in the Department of Orthopaedic Surgery at the University of Kentucky College of Medicine.

Joseph Sanfilippo, MD, recently became an examiner for the American Board of Obstetrics and Gynecology. Dr Sanfilippo is professor of ob/gyn and director of Reproductive Endocrinology in the Department of OB/GYN at the University of Louisville.

Frank Walker, MD, has been named by the Kentucky Department of Public Health as the Best Notifiable Disease Reporter of the Year for his work during the shigellosis outbreak in Jefferson County. This annual award recognizes a health care provider who makes an outstanding contribution in reporting communicable diseases.

KMA members recently appointed to hospital positions in Louisville include **James S. Holtman, MD**, 1997 Alliant Health System Adult Services Medical Staff President; **Gerald P. Rabalais**,

MD, Kosair Children's Hospital 1997 Medical Staff President; and **Fun-Far Jue, MD**, medical director for Pain Management at Baptist Hospital East.

UPDATES

Health Promotion Schools of Excellence Program Honored With AHA NOVA Award

Health Promotion Schools of Excellence (HPSE), is an innovative, comprehensive school health project for grades K-12, which had its beginning in the summer of 1991 through the Jefferson County Medical Society's Subcommittee on Health Education. Members of the committee represent the Medical Society, the Jefferson County Public Schools, and the Jefferson County Health Department. **Daniel W. Varga, MD**, president of the Jefferson County Medical Society, serves as HPSE Program Director.

This project features unique working relationships between public and private entities seeking a common goal: "A Healthier Community." The goals and development of HPSE were formulated to coincide with the directives of KERA as well as the growing pressures to control health care costs through effective preventive measures.

From the beginning, HPSE received funding from Alliant Health System and Blue Cross and Blue Shield Foundation of Kentucky. The program, nominated by Alliant, recently won the prestigious ANA NOVA Award, presented to only five hospital-sponsored community service programs in the nation.

HPSE currently serves 38 schools among Jefferson and Fayette County Public Schools.

An article on this model program for Kentucky and the nation was featured in the April 1995 issue of *The Journal of the Kentucky Medical Association*.

Dr Goodin Seeks AMA Reelection

Robert R. Goodin, MD, Louisville, is running for reelection to the AMA Council on Medical Education. He was nominated by and strongly supported by the KMA Board of Trustees. Just completing a one-year term which resulted from a vacancy and special election, Dr Goodin is seeking a full three-year term.

In his service on the Council, Dr Goodin has focused on the relevance of practice issues to medical education such as workforce concerns, manpower distribution, and the influence of managed care plans and their roles in education funding.

This election will be held during the AMA Annual Meeting in June.

MGMA Report Finds Revenue Drop in Fee-For-Service Patients

The Medical Group Management Association reports that the percentage of physicians' group revenue coming from fee-for-service patients continues to drop. The survey of 1,065 medical practices found that in 1996, multispecialty groups collected just 73.1 cents on every dollar of fee-for-service care they billed — the lowest mean in the survey's history. Most of the difference in collection figures was attributed to adjustments in the practices' contracts with various managed care entities that bring in a steady stream of patients.

Preventing Brain Damage in Bypass Patients

The University of Louisville reports that a new monitoring process is

helping eliminate the threat of brain damage in coronary bypass patients.

During bypass surgery, a patient's heart is stopped and blood is routed around the heart and lungs through a machine that keeps blood flowing. This process can create conditions that lead to brain damage. U of L anesthesiologists use a fleet of monitoring devices that check for brain wave activity, blood flow to the brain, and the amount of oxygen in the brain. If problems develop, doctors can quickly pinpoint and correct them.

A recent study showed serious brain injury occurred in a little more than 3% of all coronary bypass patients. The new methods have dropped that number to only three tenths of 1%, said anesthesiologist **Harvey L. Edmonds, PhD.**

AMA Releases Recommendations on the Oversupply of Physicians

Recently, the AMA participated in a press conference to release a consensus statement on reducing physician oversupply. The recommendations include: limiting federal graduate medical education funding to the number of US medical graduates; eliminating all waiver programs allowing non-US medical graduates to remain in the US following their training; increasing incentives and opportunities for US graduates to train and work in underserved areas; implementing an all-payer GME fund; and establishing a national physician workforce advisory body.

AMA Opposes HCFA RBRVS Plans

The AMA has expressed concern to HCFA about the government's plan to implement revisions to the practice component of the RBRVS beginning on June 1, 1998. Congress mandated the changes but the AMA questions

the precision of data being used and HCFA's ability to transform the data into accurate resource-based practice expense relative values. AMA will aggressively advocate legislation requiring a one-year delay in the implementation of this rule. Also, additional time would allow both HCFA and physician groups to work together to develop alternative values that bear some relationship to physicians' actual practice expense and not affect Medicare patients' access to quality health care services.

Directed by House of Delegates policy, the AMA has reservations about the adequacy of the data and the methodology to be used to determine practice expense relative values.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

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Frank J DeMarco Jr, MD — PUD
2600 Jackson Ave, Ashland 41101
1975, U of Florida

Timothy S Hart, MD — FP
2445 Winchester Ave Ste 3, Ashland 41101
1993, Marshall U

Patricia G Lapkin, MD — P
1800 Lexington Ave, Ashland 41101-2819
1987, U of Illinois, Chicago

Daviess

Natalie Kovtun, MD — IM
901 Princeton Rd Apt 1408, Madisonville 42431-3198
1990, Lvovij Medicinskij, Ukraine

Tudor Popescu, MD — IM
901 Princeton Rd Apt 203, Madisonville 42431-3908
1992, U of Bucharest, Romania

Fayette

Lori L Atkins, MD — R
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1986, Baylor, Houston

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2621 Lyter Ct, Lexington 40513-1462
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3320 Tates Creek Rd Ste 204, Lexington 40502-3408
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Floyd

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1986, U of Saskatchewan, Canada

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- Florante G Bautista, MD** — U
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1965, Manila Central U, Philippines
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37 Ball Park Rd, Harlan 40831-1701
1984, Damascus U, Syria
- Jose M. Echeverria, MD** — IM
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1982, Cayetano Heredia Peruvian U
- Wilfred Saldanha, MD** — IM
37 Ball Park Rd, Harlan 40831
1984, Mandalay, Burma
- Sandip U Sawardecker, MD** — OBG
37 Ballpark Rd, Harlan 40831
GOA Med Col, India
- Emilia V Thomas, MD** — IM
105 Holiday Dr, Harlan 40831-1776
1991, All India Institute, New Delhi

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2200 Elk Pointe Blvd, Jeffersonville
47130
1979, U of Panjab, Pakistan
- Pamela A Clark, MD** — PD
11812 Lakestone Way, Prospect 40059-
9000
1990, State U of New York, Buffalo
- Kristin Owen Donovan, MD** — IM
4045 Ormond Rd, Louisville 40207
1992, U of Louisville
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11604 Summer Glen Way, Louisville
40299-4362
1993, U of Kentucky
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70 Warrior Rd, Louisville 40207-1518
1986, U of Missouri
- Joseph M Jellicorse MD** — FP
1516 Yorkshire Dr, Elizabethtown
42701
1993, E Tenn U
- Raja M Kaikaus, MD** — GE
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1978, Dow, Pakistan
- Craig S Kamen, MD** — R
1214 Spring St Ste 2, Jeffersonville
47131
1990, Med Col of Ohio
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4500 Churchman Ave Ste 203,
Louisville 40215-1164

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6106 Crestwood Station, Crestwood
40014
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- Bruce L Slaughenhaupt, MD** — U
2421 Boulevard Napoleon, Louisville
40205
1988, U of Connecticut
- Robyn S Stinnett, MD** — P
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- Lisha R Thornton, MD** — IM
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3479
1993, U of Mississippi
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1985, Aristotelian U of Thessaloniki,
Greece

Johnson

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102 E Dorton Blvd, Staffordsville
41256-9009
1989, U of Ioannina, Greece

Kenton

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808 Squire Lake Dr, Covington 41017-
1360
1984, New York U Med Col

Pike

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114 Walnut Dr, Pikeville 41501
1984, E Tenn U

Pulaski

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PO Box 3556, West Somerset 42564-
3556
1985, Stanley, India

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Aaron W Crum, MD — OBG
John D Johnson Jr, MD — NS
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DEATHS

Lawrence A. Davis, MD Louisville 1917-1997

Lawrence A. Davis, MD, a retired radiologist, died February 20, 1997. A 1942 graduate of Columbia University College of Physicians & Surgeons, Dr Davis was a life member of KMA.

Diane Gussler-Lobach, MD Ashland 1952-1997

Diane Gussler-Lobach, MD an ophthalmologist, died March 5, 1997. Dr Gussler-Lobach was a 1979 graduate of the University of Louisville School of Medicine and a member of KMA.

William Edward Oldham, MD Louisville 1913-1997

William Edward Oldham, MD, a retired obstetrician/gynecologist, died March 13, 1997. A 1937 graduate of the University of Louisville School of Medicine, Dr Oldham was an active member of KMA.

John P. Glenn, MD Russellville 1907-1997

John P. Glenn, MD, a retired general surgeon, died March 24, 1997. Dr Glenn was a 1932 graduate of the University of Louisville School of Medicine and a life member of KMA.

RATES AND DATA

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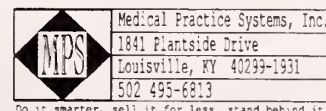
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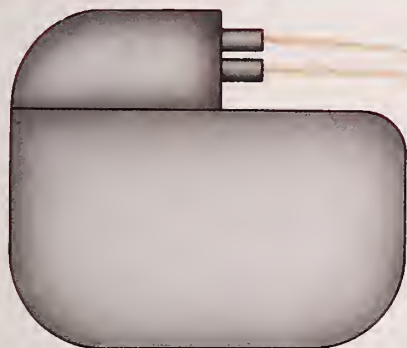
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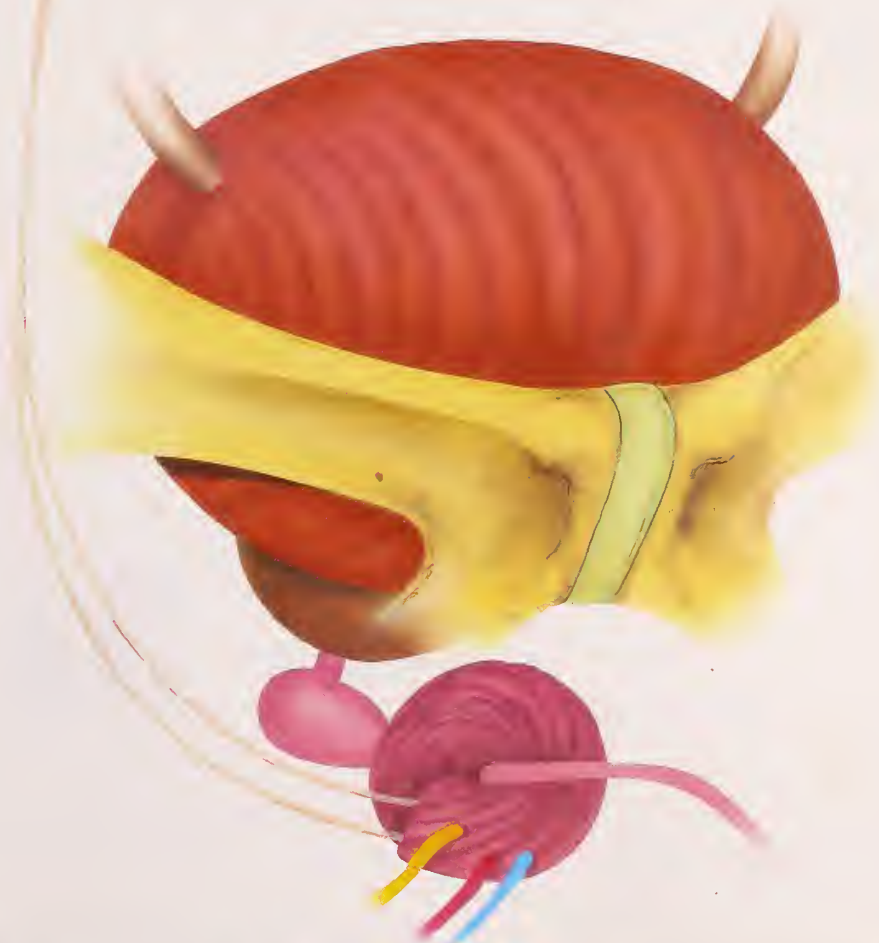
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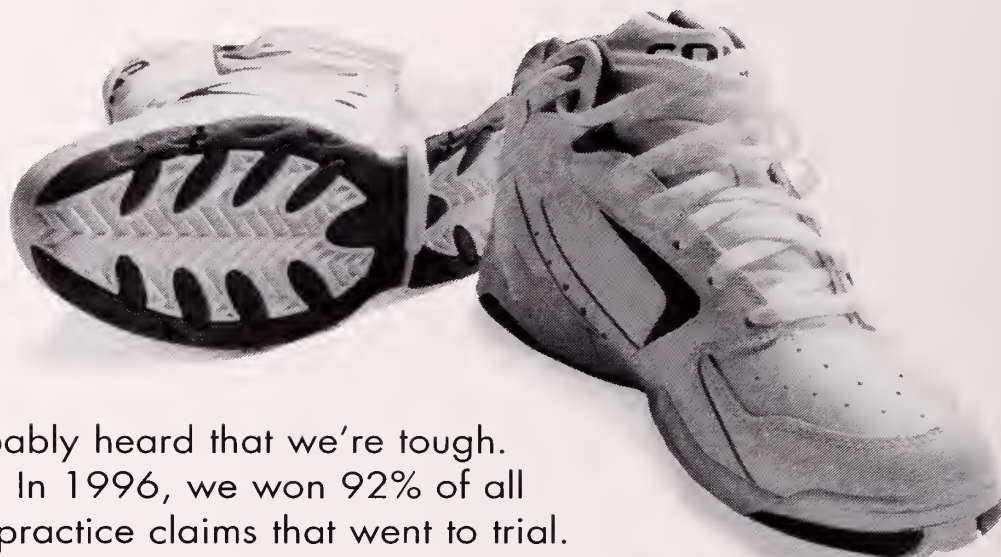
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VOLUME 95, NUMBER 6

JUNE 1997

COVER STORY

- Advances in the Management of Urinary Incontinence in Children **226**
(Grand Rounds)
John Van Savage, MD; Bruce L. Slaughenhaupt, MD

SCIENTIFIC

- Results of a Search for Missed Cases of Reportable Communicable Diseases Using Hospital Discharge Data **237**
Reginald Finger, MD, MPH; Michael B. Auslander, DVM, MSPH
- Manifestations of Relapsing Epstein-Barr Virus Illness **240**
Michael W. Simon, MD, PhD, FAAP

EDITORIAL

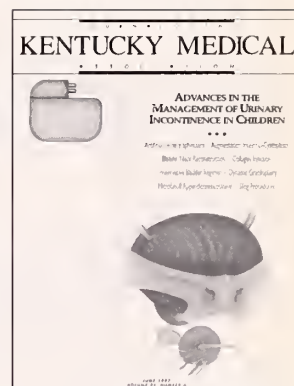
- A Daily Devotional **245**
Carolyn D. Burns, MD

ASSOCIATION

- Monitoring Medicine* **223**
KMA Board of Trustees New Officer Profiles **248**
Board of Trustees Spring Board Meeting **250**
Application for Scientific Exhibits **244**
News **251**

DEPARTMENTS

- President's Page **221**
Advertiser's Guide **254**
Alliance Page **247**
Classified **253**
Information for Authors **239**
Letter to the Editor **246**



COVER: Dynamic graciloplasty is one of many advanced procedures to treat urinary incontinence. The gracilis muscle is wrapped around the bladder outlet and then stimulated with a pacemaker (top left). The procedure will be performed in Louisville in adults in the near future. The FDA is currently reviewing the procedure for use in children. Artwork by Lee Wade of Eminence, Kentucky. (With permission to reprint from Dr Von Savage.)

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Donald C. Barton, MD

Your AMA Delegation

Starting this summer, there will be an AMA page in the *Journal* authored by our AMA Delegation. Each delegate and alternate is assigned a standing Reference Committee to cover at each meeting. Over a period of time, each of us becomes very familiar with the issues and arguments that come before our specific committee. The intent of these articles is to bring some of this inside information to the KMA membership to better inform them of the AMA's working on their behalf.

I am happy to report that the fiscal side of the AMA is doing extremely well. I have just returned from Chicago and the AMA had a great 1996, thanks mainly to the equity market. We continue to add new services and support for our members and, yet, our assets grew \$21 M in 1996. This is in spite of a loss in membership dues in 1996. At the present time, dues make up 31% of our operating budget. I'm also happy to report that our 1998 dues will remain the same.

For your information, I thought it might be nice to let you know that in addition to other members of the delegation, several KMA representatives also serve in AMA appointed or elected

"You have a very bright, hard-working delegation and I'm very proud of them. I know you are too."

positions. Bob Goodin serves on the Council for Medical Education. Bill Monnig is the Secretary of the Governing Council of the Organized Medical Staff Section and was recently appointed as a member of the Environment of Care Committee of the American Medical Assurance Program. AMAP is an ambitious effort underway by the AMA to develop a nationwide network of physician-sponsored credentialing and quality of care accreditation organizations.

Bruce Scott of Louisville is the Young Physician Delegate to the AMA House of Delegates. John O'Brien of Louisville, the chairman of the KMA OMSS, has recently been appointed to an AMA-OMSS strategic task force. Doug Scutchfield, a native Kentuckian

who recently moved to Lexington from California, serves as a delegate to the AMA House for the American College of Preventive Medicine and gives Kentucky an additional vote in the House along with Bruce. Just recently, Judy Linger was named as an Alternate Delegate from the American Psychiatric Association. Judy has been very active in the KMA and AMA and recently completed a term as a chair of the AMA-RPS.

Ardis Hoven is a member of the AMA Advisory Committee on Group Practice, and I have the privilege of serving as chairman of the Southeastern Delegation to the AMA House. This is a loose federation of 14 states and Puerto Rico.

Members of the delegation routinely serve on meeting-specific groups. As an example, in the past year, KMA delegates have served on four different reference committees. You have a very bright, hard-working delegation and I'm very proud of them. I know you are too.

Have a great summer.

Donald C. Barton, MD
Senior Delegate, AMA

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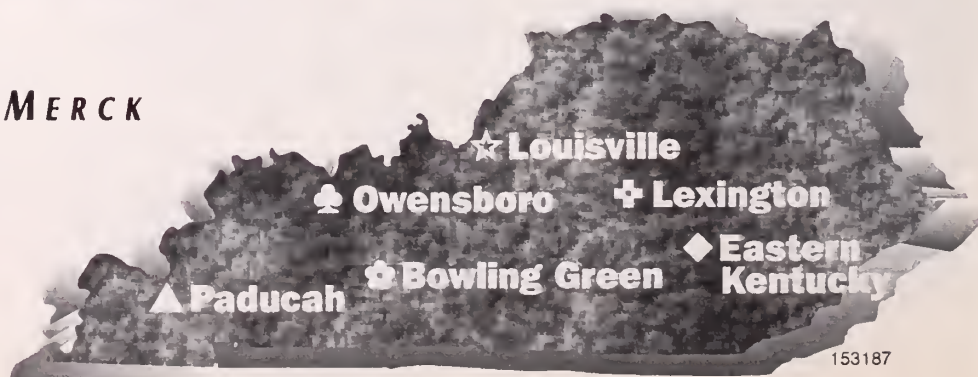


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REPORT OF THE COMMITTEE ON STATE LEGISLATIVE ACTIVITIES

Wally O. Montgomery, MD, Chair

The KMA Legislative Quick Action Committee and staff have been involved on a daily basis with either legislation, regulation, or in various task force activities. We dealt with Medicaid partnership regulations and testified on two occasions outlining the position adopted by the Board of Trustees in December. Several follow up meetings were conducted with Secretary Morse and staff. KMA got into a heated exchange with optometrists over a back door attempt to achieve credibility through the regulatory body. Essentially, optometrists lobbied the Cabinet for Health Services and members of the General Assembly to include optometrists in a section on the regulation relating to hospital staff privileges. Presently, the regulation refers only to physicians and dentists. The sole purpose of the regulation was to implement legislation adopted by the 1996 General Assembly which permitted optometrists to prescribe narcotics. While we prevailed in this skirmish, the optometrists will be back as they continue their quest for laser surgery privileges.

The Board of Nursing and Board of Medical Licensure are grappling with regulations relating to advanced registered nurse practitioners (ARNPs) and physician collaborative agreements. Collaborative agreements are required for ARNPs who choose to prescribe. We have submitted recommendations to both Boards but remain convinced that the best method to assure quality care and patient protection from abuse is via the Board of Licensure and its authority to govern physicians.

We are pleased that Attorney General A.B. Chandler III has drafted patient protection legislation that closely parallels KMA proposals. Practically every issue proposed by the KMA

House of Delegates, including an anti-gag clause, appropriate utilization review, strong deselection requirements when removing physicians from a managed care entity, and other patient protections are included. However, the Attorney General declined to include a "point of service" option in his bill. In addition, the Attorney General has also developed legislation relating to conversion of nonprofit health facilities to for-profit status. The Board has referred that legislation to the Legislative Committee.

The interim committees are beginning to crank out legislation. BR 245, an act relating to capital punishment, would permit execution by lethal injection. While there are no specifics as to how and what involvement physicians would have in the process, we have to be somewhat concerned. Several task forces are underway, including a Prescriptive Drug Abuse task force organized by the Attorney General. Rice Leach, MD, is Chair, and Don Swikert, MD, L. Douglas Kennedy, MD, and E.C. Seeley, MD, are members. William E. Doll Jr, KMA legislative counsel, is also serving. In addition, Project 2000, a task force studying long term care, is underway with Don Stephens, MD, and Don Chasteen, KMA staff, serving on that group.

As usual, there will be plenty of politics played during the 1998 Session of the Kentucky General Assembly. As you are aware, Democrats now outnumber Senate Republicans 20-18. Added to this hotbed of Senate politics is the ouster of Senate President John "Eck" Rose by Democrats joined by Republicans. Senator Larry Saunders is now President of the Senate and Walter Blevins is the Assistant President. There were no leadership changes on the House majority side.

The logo for the Kentucky Medical Association (KMA) is displayed in a stylized, bold, sans-serif font. The letters are white with a thick black outline, giving it a three-dimensional appearance. The 'K' and 'M' are particularly prominent.

Traditionally the Senate has been a very conservative body. The House routinely passes legislation without regard to merit, expecting the Senate to take care of extreme or irresponsible legislation. The shoe may be on the other foot in the '98 Session. The hostility between Governor Paul Patton and Majority Floor Leader Greg Stumbo could also complicate matters.

Health Insurance Reform is still being bitterly fought in the Frankfort trenches. The modified community rating provision appears to be the main stumbling block. Kentucky Kare, the state's health insurance "company," reports losses of \$2.6 million a month. Kentucky Blue Cross and Blue Shield, the only other company offering policies to individuals, also reports huge losses.

According to Insurance Commissioner Nichols over 42 health insurance companies have left the Kentucky market.

These and other issues make life interesting around the General Assembly. The '98 Session is only nine months away so physicians need to begin working with their legislators.

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATIVE ACTIVITIES

Donald C. Barton, MD, Chair

Federal elections will highlight the election season in 1998 with the US Senate seat of Wendell H. Ford capturing much of the attention. Congressman Jim Bunning appears to be the favorite among Republicans. On the Democratic side, Congressman Scotty Baesler has announced his intent to run.

As a result of Ford's retirement and Bunning and Baesler leaving Congress, there will be considerable side effect to Kentuckians in terms of political power and prestige. As a small state, longevity in office is Kentucky delegation's only leverage as they battle larger states for influence. Wendell Ford retires in 1998 as the second most powerful Senate Democrat in Washington. Although rarely seeking public attention, he serves as minority whip and member of the powerful Senate Rules Committee. On the House side

Kentucky loses the power of both Congressmen Bunning and Baesler. Bunning is a member of the Budget, Ways and Means, and Chair of the Social Security Subcommittee. Baesler, a member of the Budget Committee, is also extremely powerful in agricultural circles, an area in which Kentucky is so dependent. Tobacco will take a huge hit with the loss of Ford and Baesler, two of Washington's most vocal and powerful protectors. The anti-tobacco forces have already noted Ford and Baesler's departure believing it to be the beginning of the end for tobacco industry's influence.

The 105th Congress convened in January with 74 new members of the US House and 15 new US Senators, while the 104th Congress ushered in a freshman class almost as large, with 91 freshmen and 9 new senators. During the 104th Congress, almost

8,000 bills were introduced in Congress. As of March 3, 1997, a total of 1,551 bills have been introduced in the 105th Congress. Members of the House have introduced 1,076, while senators have introduced 475. A large number of these bills pertain to items on medicine's legislative agenda for 1997. Such issues as eliminating gag clauses in managed care contracts, patient confidentiality, medical liability, definition of emergencies, and Medicare and Medicaid reform will be making their way to the floor of the House and Senate.

HR 586, sponsored by Representative Ganske of Iowa, would prohibit gag clauses. Three Kentucky Congressmen—Whitfield, Lewis, and Baesler—have joined on as co-sponsors. Tort Reform continues to be of major concern to AMA. Senate Bill 5, legislation relating to product liability, is AMA's best hope for

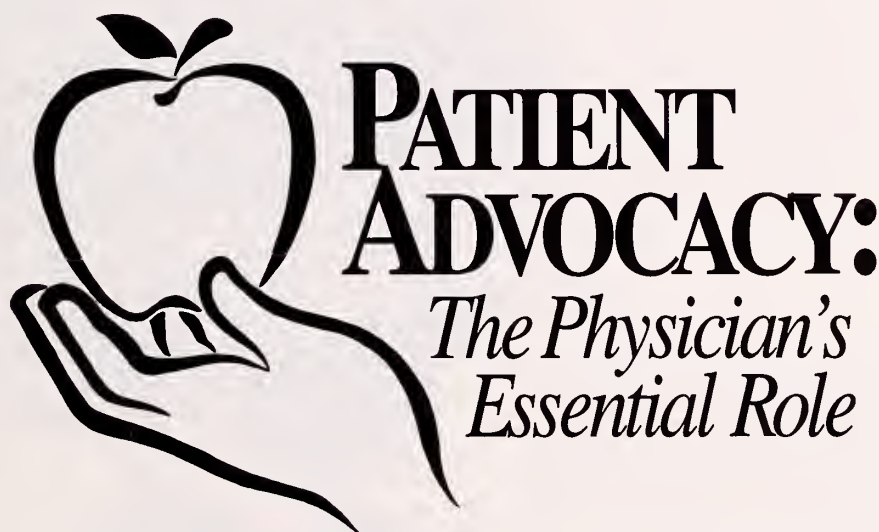
achieving liability relief. AMA is seeking support for an amendment to S 5 which would cap non-economic damages at \$250,000. Wendell Ford is on the Committee dealing with this legislation.

Changes in physicians' fee structure are obviously at the heart of AMA's legislative agenda. AMA favors a gradual shift to a single physician conversion factor rather than an immediate change. AMA continues to meet with HCFA on the development of resource-based practice expense

relative value. AMA points out that the requirement that Medicare's resource-based relative value scale (RBRVS) remain budget neutral from year to year imposes a serious constraint on its ability to accurately reflect physicians' practice expenses. Both the Administration and Congress have recognized that physicians are not the culprits as far as rising Medicare costs. Clinton projects a \$100 billion savings over five years in Medicare through reimbursement reductions, managed care, and fraud and abuse.

In 1970 Medicare totaled 3.7% of the federal budget; today it consumes 13%.

Medicaid is also a major target as Clinton seeks cuts of \$9 billion. The President and Congress are also looking at savings through disproportionate share funds reimbursed primarily to hospitals for indigent care, state flexibility via Medicaid waivers, and the old standby—fraud and abuse.



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Advances in the Management of Urinary Incontinence in Children

John Van Savage, MD; Bruce L. Slaughenhaupt, MD

Urinary incontinence, or the involuntary loss of urine, affects 10 to 12 million people in the United States annually, including a significant percentage of children. Boys and girls both are affected by this condition, but girls tend to have daytime incontinence and boys tend to have nocturnal enuresis. The purpose of this article is to help clinicians distinguish between the uncomplicated and the complicated cases of urinary incontinence in order to provide the best possible treatment regimen.

Under normal circumstances, the bladder stores urine and then empties it approximately every 4 hours. A healthy bladder accommodates increasing volumes of urine at low intravesical pressures. With the appropriate sensation, the mind knows when the bladder should be emptied. The bladder outlet remains closed when the body is at rest and also during increasing intra-abdominal pressure. When the bladder reaches its capacity and is voluntarily emptied, there is a coordinated contraction of the bladder's smooth musculature and a concomitant lowering of resistance of the smooth and striated muscle sphincters. However, if there is an involuntary bladder contraction before the bladder reaches its capacity, urine may escape.

Classification of Urinary Incontinence

We begin our assessment of urinary incontinence by classifying the child's condition as urge, stress, overflow, or continuous incontinence. The following is a brief description of each.

Urge Incontinence

A classic example of urge incontinence secondary to detrusor instability is a 6-year-old girl who urinates frequently and also has accidents. This is often secondary to an immature bladder, and the patient may respond to a conservative bladder regimen (Table 1).

Stress Incontinence

Stress urinary incontinence rarely occurs in children, especially young girls, since pelvic structures and the urethra are still well supported by the muscles and ligaments of the pelvic floor. The majority of stress incontinence cases usually occur in children with spina bifida who have intrinsic sphincter deficiency or nerves to the sphincter that do not work normally and leave the sphincter flaccid.

Overflow and Continuous Incontinence

Overflow incontinence occurs when the nerves to the bladder and the bladder outlet are not working properly. As a result, the bladder simply fills and overflows frequently. This is different from continuous urinary incontinence, which is usually secondary to an anatomic defect, such as bladder exstrophy, an ectopic ureter in the vagina or the urethra (outside the sphincter mechanism), or patent urachus.

Uncomplicated Versus Complicated Incontinence

Once the symptoms of urinary incontinence have been classified, we then distinguish the uncomplicated from the complicated cases (Fig 1). The severity of the incontinence is usually determined by urinalysis, neurologic examination, voiding cystourethrography (VCUG), uroflow, and/or urodynamic studies.

Table 1. Conservative Bladder Regimen

<p>Timed voiding and no urine holding. Drink plenty of fluids in the daytime, but not after 6:00 pm Avoid caffeine. Avoid constipation. Good perineal hygiene, but do not take bubble baths.</p>
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Urinary Incontinence in Children

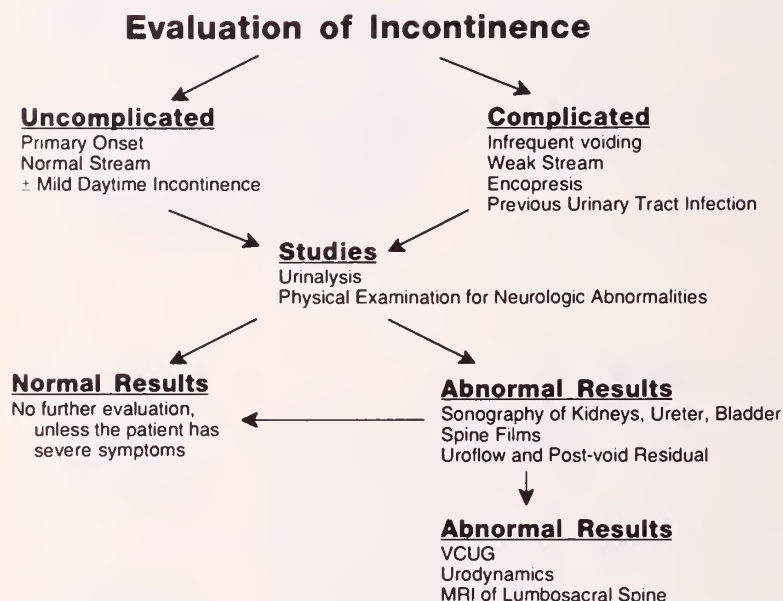


Fig 1 — An algorithm illustrates the different evaluation procedures for uncomplicated and complicated cases of incontinence. Abbreviations: VCUG, voiding cystourethrogram; MRI, magnetic resonance imaging.

Uncomplicated Incontinence

The most common type of uncomplicated urinary incontinence is known as the frequency, urgency, and nocturia (FUN) syndrome. Despite being referred to as the FUN syndrome, children with this condition experience irritative voiding symptoms. Fever and constitutional symptoms are not typically associated with this syndrome, and the results

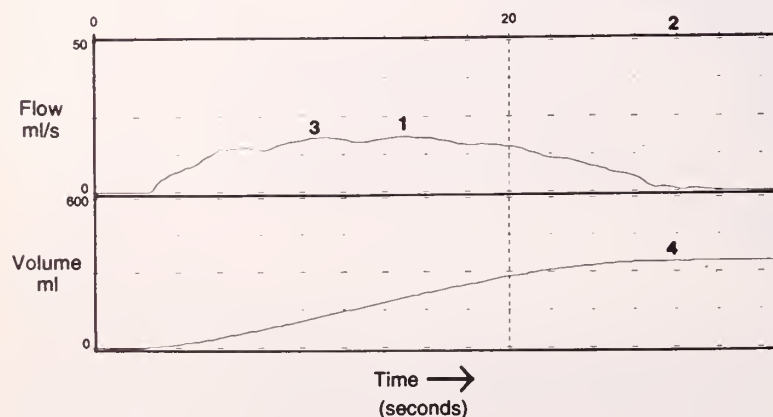


Fig 2 — An example of a normal uroflow in a 10-year-old child. 1 = maximum flow (18.3 ml/s), 2 = voiding time (25 seconds), 3 = time to peak flow (8.4 seconds), and 4 = voided volume (343.7 ml). The bell curve depicted in the flow area (Top) indicates normal coordinated voiding.

of urinalysis and neurological studies are usually normal. There is no pyuria. The syndrome generally occurs in girls and boys with small bladders. We recommend a conservative bladder regimen (Table 1) to treat patients with the FUN syndrome. This regimen has proved to be effective in approximately 80% of children with this syndrome and can also be used for enuresis. In children with very small bladders, anticholinergic therapy in addition to the conservative regimen (Table 1) is recommended.

Complicated Incontinence

When childhood urinary incontinence is severe or accompanied by either encopresis or urinary tract infection, the incontinence is considered complicated (Fig 1). In these situations, sonography of the kidneys, ureter, and bladder rules out the majority of urinary tract anatomic abnormalities.

For a child with recurrent urinary tract infections combined with incontinence, the standard recommendation is to obtain a VCUG. In a 1992 study of children with pyelonephritis,¹ no child with a normal renal ultrasound and dimercaptosuccinic acid (DMSA) scan was found to have vesicoureteral reflux. In children who have a sibling with reflux, we use a sonography of the kidneys, ureters, and bladder; a uroflow with post-void residual; and DMSA scan with SPECT (single-positron emission computerized tomography) to test for the presence of urinary tract dilatation, bladder function, and renal scarring. SPECT is a nuclear medicine CT scan of the kidneys and is the best test available for detecting renal scarring. It is important to have a sonography when the patient's bladder is both empty and full. If the sonography, DMSA scan with SPECT, uroflow, and post-void residuals studies are normal, we sometimes forego a VCUG to avoid catheterizing the child, particularly those older than 2.

The uroflow is a screening test for bladder dysfunction. It enables clinicians to rule out obstructive and dysfunctional voiding and is best combined with a post-void residual volume assessed by sonography. A normal uroflow for a 10-year-old child is shown in Figure 2, with a residual volume of zero (Fig 3).

We use the results of nomograms for different age groups to determine the uroflow maximum and average flow rates to rule out urinary outflow obstruction. In Figure 2, the bell-shaped curve depicts normal, coordinated voiding, whereas a flat line is more consistent with obstruction such as that caused by posterior urethral valves. A urinary

flow curve with a sawtooth pattern of staccato voiding is consistent with pelvic floor dysfunction and the inability to relax during urination. This is a more complicated problem, and may require biofeedback therapy. When this condition is left untreated, it may produce gradual overdistension of the bladder, ureters, and kidneys. This has been termed the Hinman syndrome or the non-neurogenic neurogenic bladder.

The **voided volume** is the amount of urine a bladder will normally hold prior to urination. The average volume should be equal to the age of the child plus 2, multiplied by 30 ml. The voided volume shown in Figure 2 for a 10-year-old child is 343.7 ml. Assessing the efficiency of bladder emptying can be misleading without the results of post-void residuals or VCUGs. For instance, the normal **voided volume** for a 5-year-old child is 210 ml $[(5 + 2) \times 30]$. The post-void residual volume for one child may be zero (normal) and for another child 300 ml (abnormal). Both children seem to urinate the same amount, but only one empties his or her bladder (Fig 3). A high post-void residual volume predisposes a child to urinary stasis and infections.

When to Refer a Patient to a Pediatric Urologist

If no improvement occurs after the conservative bladder regimen (Table 1), with or without anticholinergics (usually Ditropan®), and if ultrasonography and VCUG have not elucidated the problem, surgical referral is indicated. About 20% of children with urinary incontinence who do not respond to the conservative bladder regimen are referred to a pediatric urologist for further assessment or surgery.

Neurogenic Bladder

It is more common to find a functional abnormality or neurologic problem than an anatomic cause of urinary incontinence. The pediatric urologist reserves urodynamic studies for children with symptoms of a neurogenic bladder or a documented neurogenic bladder. Once a catheter is hooked up to a special transducer, the urodynamic study assesses filling and emptying. We examine both the detrusor muscle and the bladder outlet. During filling, the detrusor is characterized according to its capacity, compliance, and presence or absence of detrusor instability.

We define a safe **capacity** as that in which the urine is stored at less than 30 cm water pressure. Pressure greater than 30 cm of water places the

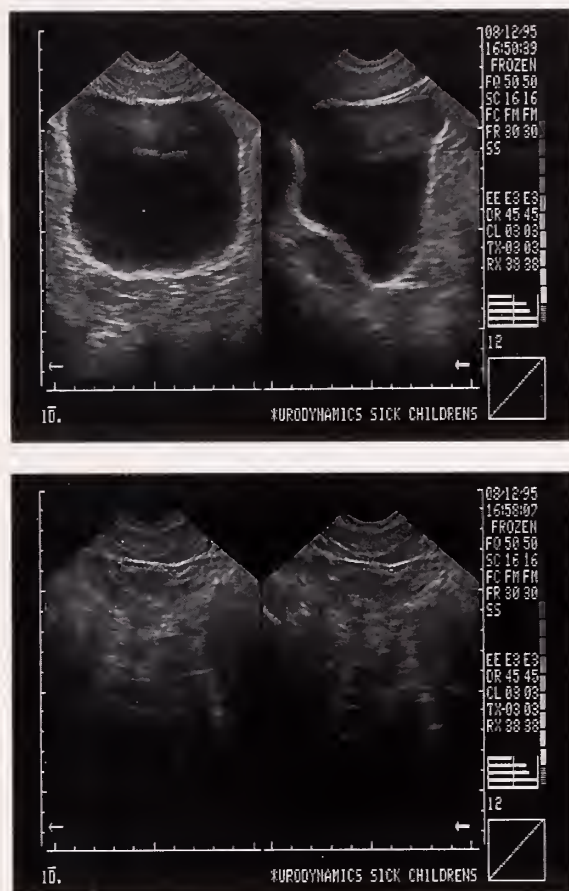


Fig 3 — Pre- and post-void bladder sonography is a painless way to document bladder emptying (post-void residual). Top, full bladder. Bottom, empty bladder = zero post-void residual.

upper urinary tracts at risk or predisposes the child to urinary incontinence as a pop off valve² (ie, the pressure in the bladder is either transmitted to the kidney as back pressure or the bladder outlet as incontinence).

The **compliance** is the change in volume over the change in pressure. An analogy for this might be that the normal bladder is like a balloon, while a neurogenic bladder is like a hot water bottle. A balloon is compliant and can increase its volume without significantly increasing the pressure and can fill and empty repetitively. A hot water bottle does not have good compliance and increases in pressure as it fills and also has trouble emptying.

During the filling phase of urodynamic studies, the **bladder outlet** is observed for leak-point pressure, which is the pressure at which the

Urinary Incontinence in Children

child leaks urine. Normally, if a child laughs, sneezes, or coughs, no urine is expelled from the urethra. In children with intrinsic sphincter dysfunction secondary to spina bifida or other neurologic problems, the pressure at which urine leaks from the bladder outlet is low.

The emptying phase of the urodynamic study determines both the flow rate and post-void residual volume. The pediatric urologist can observe how the bladder outlet is performing during emptying with a pressure flow study to confirm that there is no anatomic obstruction to outflow. This is much more common in adults with benign prostatic hyperplasia, but also is possible in children with posterior urethral valves.

In older children, when the bladder does not empty and the child has high bladder outlet pressures, we recommend clean-intermittent catheterization every 4 hours, and administration of Ditropan[®], 5 mg orally three times per day, in children over 5 years of age. This regimen is effective in an additional 15% of children presenting with urinary incontinence. When combined with the conservative bladder regimen, 95% of all children with urinary incontinence improve. If these children continue to lose urine, they become candidates for surgery.

Minimally Invasive Surgery for Incontinence

Collagen Injection

The problem with any bladder outlet resistance procedure is that the minimally invasive procedures are also usually minimally effective, whereas the more invasive and complex procedures yield

significantly better results. For example, collagen injection into the bladder neck for urinary incontinence in children yields an approximately 20% success rate.³ Multiple injections may be required on an outpatient basis. This procedure is best used in a child who is mostly dry, and who uses only one or two urinary pads per day. If a child is completely wet, the chance of collagen injections completely resolving incontinence is low. If residual incontinence persists after another more invasive procedure, the collagen may add the extra bulk to the bladder neck that promotes complete continence. The results at the time of operative procedure in terms of coaptation of the bladder neck coincide with the clinical results. In other words, an open bladder neck (Fig 4, left) should coapt nicely after collagen injection (Fig 4, right).

Sling Procedures

The pubovaginal or puboprostatic fascial sling is a hammock that wraps around the bladder neck and pulls it up towards the pubis to provide a passive increase in resistance to urinary incontinence. This procedure works well in the augmented bladder, with results approaching 90%.⁴ Approximately two-thirds of patients without bladder augmentations become acceptably dry (ie, requiring a minimal number of urinary pads). The procedure is minimally invasive and easily performed as a solitary procedure that requires hospitalization of approximately 1 to 2 days. We use a Pfannenstiel incision for most of our operations. The incision provides excellent cosmesis, is nearly invisible, and parents are more willing to accept a procedure that is minimally invasive and requires only a small incision.



Fig 4 — Injection of collagen into open bladder neck (left) produces good coaptation (right) to prevent urinary leakage.

More Invasive Surgical Procedures

Augmentation Cystoplasty

Surgery on the neurogenic bladder can increase the bladder outlet resistance and achieve continence, or create a larger, lower pressure bladder to lower the pressure exerted on both the bladder outlet and the kidneys. The augmentation intestincystoplasty has shown excellent results for improving both continence and preserving the upper urinary tract. However, it is associated with complications of excessive mucous production of the augmented bowel in the bladder, hyperchloremic metabolic acidosis, bladder stones, and increased urinary tract infections. Therefore, we generally avoid this procedure, except in select children. A good candidate among those requiring an augmentation cystoplasty is a child who has severe hydronephrosis on one side, with limited function. In such a child, we remove the nonfunctioning kidney and use the ureter and renal pelvis to augment the bladder. This procedure has excellent results and is not associated with any of the aforementioned complications of interposing bowel into the urinary tract.⁵ We recently performed this operation on a boy with cloacal exstrophy, severe hydronephrosis, and a nonfunctioning segment of a horseshoe kidney. After surgery, his bladder storage had greatly improved, and there was less pressure from the bladder on the remaining kidney and bladder outlet.

Artificial Urinary Sphincter

The artificial sphincter has been greatly improved over the last two decades, mainly because of better materials and better component design. It has a cuff that squeezes the bladder outlet to prevent leakage, a pump to empty the cuff when it is time to urinate, and a balloon to hold extra fluid pumped from the cuff (Fig 5). It refills automatically in 2 to 3 minutes, and the child is dry. Long-term studies have been performed in children with an overall success rate of 77%, according to one multi-institutional study.⁶ The half-life of an artificial urinary sphincter is about 12 years. The chance of mechanical failure requiring replacement or repair of one of the components of the sphincter is approximately 50%. The erosion rate is approximately 10%, and the infection rate is 2%.

The best candidates for the artificial urinary sphincter are those who have not had previous bladder outlet surgery and have a good bladder compared to those who have undergone previous

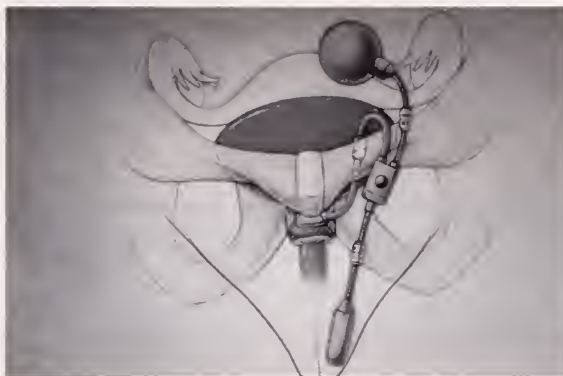


Fig 5 — An artificial urinary sphincter in a female patient. The cuff around the bladder neck produces continence, and the pump allows fluid to be moved from the cuff to the balloon so voiding may occur.

procedures and have a borderline bladder. It has been shown that placing an artificial urinary sphincter with an augmentation intestincystoplasty does not increase the infection rate, provided that the surgery was meticulously performed, and there was good antibiosis. The advantage of the urinary sphincter is that patients are completely continent 85% of the time if the sphincter still works at 5 years' follow-up. It also does not reconfigure the bladder neck, so it does not preclude other procedures. Since the artificial urinary sphincter involves the use of mechanical devices, the patient may require reoperation to repair the device should the component fail. The procedure is used in both boys and girls (Fig 5). In younger children, the artificial sphincter cuff is placed around the bladder neck, and in the older male child it is placed around the bulbar urethra.

Dynamic Bladder Outlet Graciloplasty

Dynamic graciloplasty is a substitute for the artificial urinary sphincter in men after prostate surgery and for the pubovaginal sling procedure in women after more simple procedures have failed. It has several advantages over the other procedures since the pressure exerted by the gracilis muscle sphincter on the bladder outlet can be adjusted postoperatively so that it is not too tight or too loose. A sphincter that is too loose would result in persistent urinary incontinence, while one that is too tight would produce ischemia and erode into the urethra and may make a stricture. The neosphincter is resistant to infection and is created with living autologous tissue with the patient's own blood and nerve supply.

With the graciloplasty procedure, the gracilis muscle is wrapped around the bladder outlet and then stimulated with a pacemaker (Fig 6). The fatigable gracilis striated muscle is trained electrically over an 8-week period to become a nonfatigable sphincter muscle. The patient passes a magnet over a subcutaneous pacemaker box to turn it off in

Urinary Incontinence in Children



Fig 6 — A dynamic graciloplasty in an adult male. This procedure is a substitute for an artificial urinary sphincter in men after prostate surgery or in women after a failed pubovaginal sling procedure, but may be used in the future to treat children with complicated urinary incontinence. A pacemaker controls the gracilis neosphincter.

order to void or catheterize. He or she then turns it back on with the magnet to restore continence. Initial results in Europe with this procedure indicate a 50% rate of success.⁷ However, with refinements in the technique and a better patient selection, the results are closer to 90% for achieving social continence (Michael Chancellor, University of Pittsburgh, personal communication).

We will be performing this procedure in adults in the Louisville area in the near future. The FDA has not yet approved the procedure for use in children. However, once FDA approval is given, whenever a child needs to void, he or she simply waves a magnet over the bladder outlet pacemaker to turn it off. This advanced surgical procedure will allow children to both empty the bladder and remain continent between emptyings.

Bladder Myoplasty

A successful dynamic gracilis neosphincter would rid an adult or child of diapers. However, some children can neither control their bladder outlets

nor bladders and remain in diapers despite catheterizing to empty their poorly contracting bladders. Work is under way to wrap the latissimus dorsi muscle around the bladder and have it contract when the patient tenses their abdominal wall. This would empty a bladder that cannot contract on its own, and free the child of catheterizations. Another option we are looking into is wrapping part of the rectus muscles around the bladder and stimulating them with a pacemaker to empty the bladder. Our long-term goal is to have an operation that can control both the bladder and the bladder outlet with skeletal muscle so a child or adult can control his sphincter and bladder without catheters or diapers.

Bladder Neck Reconstruction

The bladder neck reconstruction procedure is used for children with bladder exstrophy and in select children with other complex causes of urinary incontinence. This procedure involves lengthening the urethra or creating a flap valve mechanism to possibly increase urinary outflow resistance. The success of the procedure also depends on the presence of a low-pressure, high-capacity bladder.⁸

Mitrofanoff Appendicovesicostomy

For the child who needs to be catheterized but has difficulty catheterizing him or herself through the urethra because of pain, inaccessibility, or urethral damage, the creation of an appendiceal conduit to the umbilicus enables self-catheterization easily. This procedure is called a Mitrofanoff appendicovesicostomy. The umbilicus appears normal. Using a new "urethra," the child can empty the



Fig 7 — The four components of the Mitrofanoff principle. This is a procedure that creates an alternate urethra in children who need to be catheterized but have pain, physical limitations, or other difficulties catheterizing their native urethras.



Fig 8 — The Mitrofanoff appendicovesicostomy is used as an alternate urethra and involves the interposition of the appendix (conduit) between the umbilicus (stoma) and the bladder (reservoir). A flap valve created at the junction of the bladder and the appendix keeps the Mitrofanoff from leaking (Bottom Right). The umbilical stoma is invisible, and the bladder is easily emptied by the child with a catheter (Top Right and Left).

bladder every 4 hours easily and conveniently. The procedure works well and has undergone several refinements over the years.⁹

The four components are shown in Fig 7. The **stoma** can be in the right or left lower quadrant, as well as the umbilicus. The **conduit** can be the appendix (Fig 8), a gastric tube, ureter, tapered ileum, or other bowel segment.¹⁰ The **continence mechanism** for this alternate urethra is a flap valve created in the bladder. The last component is a high-capacity, low-pressure bladder. A limiting factor for the Mitrofanoff appendicovesicostomy procedure is the presence of stomal stenosis. We have recently modified our technique to produce a patent stoma in 92% of the cases.¹¹

This may be a complex surgical procedure, but it provides the child with a better quality of life (Fig 8). Children prefer this method because they

Urinary Incontinence in Children

can readily see the umbilicus (or stoma in other sites) and can catheterize themselves unobtrusively. Another advantage of the Mitrofanoff appendicovesicostomy is that it increases the success rate for any bladder outlet surgery. By not using a surgically repaired bladder outlet for catheterization, artificial urinary sphincters and reconstructed bladder necks last longer. If the efficiency of voiding increases, and the patient no longer requires catheterization, the Mitrofanoff can be left in place, hidden in the umbilicus.

Conclusion

Controlling the function of the urinary tract, either with internally applied electrical stimulation, artificial urinary sphincters, reconstructive surgery, or with a conservative medical regimen is oftentimes a better alternative than diapers for children with urinary incontinence. Freedom from the social stigma of urinary incontinence is very important in children. Given the state-of-the-art procedures now employed, no child should enter adolescence in diapers or wearing urinary pads.

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Results of a Search for Missed Cases of Reportable Communicable Diseases Using Hospital Discharge Data

Reginald Finger, MD, MPH; Michael B. Auslander, DVM, MSPH

To assess how reliably hospitals report serious, uncommon communicable diseases to the Department for Public Health, we searched the 1995 hospital discharge data set (HDDS) collected by the Kentucky Health Policy Board for cases of 11 diseases. Of 17 case records found, 4 represented disease occurrences that had been reported to the Department; 6 represented coding errors in the HDDS; 4 were instances where a reportable disease had been suspected but not confirmed by subsequent workup; 1 case was a resident of another state; and 2 were cases of invasive Hemophilus influenzae infection in adults that should have been reported to the Department. The study found no evidence that hospitals failed to report vaccine-preventable diseases. There was evidence that the HDDS needs improved accuracy to maximize its usefulness for public health purposes.

Surveillance for conditions of public health importance has been a central function of the state public health agency, in Kentucky as in other states and countries, for more than a century. In recent decades, surveillance efforts have expanded beyond infectious diseases to include chronic conditions and injuries. However, timely reporting of serious communicable diseases remains a top priority. In the last few years, substantial new state and federal resources have been invested in vaccines and in delivery of immunization services. In order to document a return on this investment, we must have confidence in our ability to detect any remaining cases of vaccine-preventable diseases. Moreover, we must have epidemiologic and laboratory systems in place to detect emergence of resistant bacterial infections, and of new infectious diseases, in order to minimize their impact.

In 1995, occurrences of 58 different communicable diseases were legally reportable to the

Department for Public Health. This list was updated in 1985, again in 1989, and again in May 1997 in order to focus our efforts on the conditions that clearly need public health attention. Reports of these diseases are kept in a confidential reportable disease registry (RDR), from which monthly and annual reports as well as special surveillance summaries are published. Since 1986, the Department has electronically sent a weekly line-listing of cases (without names or personal identifiers) to the Centers for Disease Control and Prevention in Atlanta. These reports from the states form the basis for almost all published references to the incidence of any communicable disease in the US. Reportable disease data from 1986-95, stripped of identifiers, are made available on electronic media to researchers on request.

Given the public health importance and widespread utilization of these data, it behooves us to make sure that they are as complete and accurate as possible. For many years, the Department has looked for ways to validate the reports against some other data set. The enactment of health care reform in 1994 provided this opportunity. As part of an effort to compare health care costs and quality, hospitals are now required to submit line-listed information from each patient admission to a hospital discharge data set (HDDS), formerly housed in the Health Policy Board, and now in the Department for Public Health. Health Policy Board staff estimated that data representing 80% of all discharges had been reported by hospitals for calendar year 1995 as of the date of the study. Each record contains ICD-9-CM codes corresponding to the principal diagnosis occasioning the admission as well as other diagnoses made during the hospitalization.

Methods

We selected 11 uncommon communicable dis-

Missed Cases of Reportable Communicable Diseases

eases: botulism, cholera, diphtheria, ehrlichiosis, *Hemophilus influenzae* invasive disease, measles, mumps, pertussis, poliomyelitis, rubella, and tetanus. These encompass all diseases preventable by routine immunization except hepatitis B, plus three others of particular public health interest. We electronically searched the HDDS for records with ICD-9-CM codes (see table) corresponding to those diseases for calendar year 1995. These records were then matched with reports from the RDR using gender, county of residence, date of birth, and approximate date of diagnosis. For each record that did not match, we contacted the infection control practitioner at the hospital by telephone and obtained information about the case. The reasons for failure to match were classified into (1) confirmed cases of disease which should have been reported to RDR; (2) cases where the disease was suspected but not confirmed; and (3) coding errors in the HDDS.

Results

The findings from the match are seen in the Table. Sixteen records were found in the HDDS which had a diagnosis code for one of the 11 diseases; one other had codes for two diseases. Of these 17, 4 matched with cases of that disease in the RDR.

Table

# Disease(s)	ICD-9 code(s)	Matched with RDR?	Reason for non-match
1 Botulism	005.1		
tetanus	037	no	coding error
2 Cholera	001	no	coding error
3 Ehrlichiosis	083.8	no	unconfirmed case
4 Ehrlichiosis	083.8	no	coding error
5 <i>H influenzae</i>	320.0	yes	---
6 <i>H influenzae</i>	320.0	yes	---
7 <i>H influenzae</i>	320.0	no	failure to report
8 <i>H influenzae</i>	320.0	no	failure to report
9 <i>H influenzae</i>	320.0	no	unconfirmed case
10 <i>H influenzae</i>	320.0	no	unconfirmed case
11 <i>H influenzae</i>	320.0	no	coding error
12 Pertussis	033	yes	---
13 Pertussis	033	yes	---
14 Pertussis	033	no	out of state case
15 Pertussis	033	no	unconfirmed case
16 Rubella	056	no	coding error
17 Tetanus	037	no	coding error

Note: no records were found in HDDS with diagnoses of diphtheria, measles, mumps, or poliomyelitis.

Of the remaining 13 records, 6 represented coding errors in HDDS. One of these was the patient with two "diseases." This patient had been admitted with bacterial sepsis; a gram-positive rod was isolated from the blood and thought at first to be *C tetani* or *C botulinum*. The organism was ultimately identified as *Bacillus sp.* However, the patient had no symptoms or signs of either botulism or tetanus and the record coding the patient as having these diagnoses was in error. In another case, the patient was coded as having tetanus. This patient had dislocated his jaw and was admitted for orthopedic surgery. However, the ambulance run report used the term "locked jaw," which was erroneously coded as "lockjaw" (=tetanus).

Four of the records represented cases in which the diagnosis of the disease was suspected but not confirmed. In all cases the suspicion was remote enough that we deemed the decision not to report the case as reasonable. One patient was suspected to have *H influenzae* meningitis, but subsequent workup clearly demonstrated that she had a viral meningitis, and the case indeed was reported as such to the RDR. Another case which was thought at first to be ehrlichiosis, turned out instead to be Rocky Mountain Spotted Fever, and did appear as RMSF in the RDR.

In another situation, the patient had confirmed pertussis, but was a resident of another state. The physician had indeed reported the case to the health department in that state, but the report was received 5 months after hospitalization.

The final two cases represented instances in which Kentucky Department for Public Health should have been notified. These two were culture-confirmed cases of *H influenzae* infection in adults. One was a sepsis, the other a meningitis resulting from a tear in the meninges. The reason for non-reporting in both cases was that the infection control practitioner had not understood the case definition to include any isolation of *H influenzae* from a normally sterile site regardless of age.

Discussion

This study did not find a significant failure on the part of the hospitals to report cases to the RDR. This reassures us regarding the completeness of the RDR, at least for the diseases studied. The two missed cases did not represent instances of vaccine-preventable disease (VPD), which would be of primary concern. If the RDR is missing cases of VPD (other than hepatitis B), they probably are those either not severe enough to be hospitalized,

or those in which the diagnosis was not suspected. Hepatitis B was not included in this study because most records in the HDDS are likely to represent infections of long or uncertain duration. Surveillance for hepatitis B focuses only on cases which are clearly acute, and on any infections in children under 5 (young enough to have been routinely vaccinated).

The findings did show that coding errors are frequent in this early release of the HDDS. It is unknown how widespread the errors may be throughout the data set; clearly, however, ongoing improvements to the HDDS in terms of both completeness and accuracy must continue further before it can be useful for measuring the burden of various diseases for public health purposes. A second data set, covering outpatient visits, has been planned as part of the health care reform package and is expected to be available soon. This data set will provide an opportunity to validate the RDR for diseases not requiring hospitalization. Like the HDDS, however, it may be prone to coding errors, at least in its first year.

Timely reporting of communicable diseases by clinicians, hospitals, and laboratories must continue to be emphasized at every opportunity.

ACKNOWLEDGEMENTS: The authors thank David Meacham and Charles Kendell for providing HDDS data, and the infection control practitioners of 13 Kentucky hospitals for reviewing individual case records.

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Manifestations of Relapsing Epstein-Barr Virus Illness

Michael W. Simon, MD, PhD, FAAP

Dr Simon is in a private pediatrics practice in Lexington, KY.

The Epstein-Barr Virus is well known for its pattern of communicability and features of clinical disease. It is a member of the herpes virus family and may establish a latency state in infected individuals. Characteristics of latency and reactivation have been well defined for both herpes and varicella. The Epstein-Barr Virus has been shown to establish a latency state within B lymphocytes, salivary gland epithelium, and oropharyngeal epithelial cells. Reactivation of the virus from these sites could produce relapse of EBV illness. Characteristics of relapse are described in this report.

The Epstein-Barr Virus (EBV) is a frequent cause of communicable disease in children. Most individuals are infected early in life.¹ Cases may occur sporadically from social contacts or from intrafamilial spread.^{2,3} The manifestations of infection are age dependent, producing mild or inapparent illness in young children or symptoms of mononucleosis in teenagers and young adults.^{1,9} The Epstein-Barr Virus may also be associated with apnea in infants.^{10,11}

Diagnosis may be made through clinical, physical, and laboratory features.¹² Treatment is through general supportive measures. The recovery of each individual is variable and may take several weeks to several months. During the convalescent phase of the illness, decreased activity tolerance, fatigue, depression and relapses may occur.^{4,5}

The symptoms, frequency, and predisposing factors for relapse of EBV illness are unknown. Other viruses of the DNA family, most notably herpes and varicella, have been well defined for their latency state and characteristics of relapse. The Epstein-Barr Virus has been shown to establish a latency state within B lymphocytes,¹³ oropharyngeal epithelial cells,¹⁴ and salivary gland epithelium.¹⁵ Reactivation of virus from these sites could produce recurrence of illness. This report reviews six cases of relapsing EBV illness.

Case 1

A 10½-year-old white male presented with a 1 month history of malaise, fatigue, and 1 week history of sore throat. He was afebrile at the time of examination. Diagnosis of EBV illness was made based upon clinical features, examination, and a complete blood count (CBC) with manual differential showing atypical lymphocytes. The diagnosis was confirmed by a positive EBV antibody profile. He improved and resumed normal activities.

Ten weeks after his initial diagnosis he had resumption of fatigue, malaise, and sore throat with development of headache. Examination showed swollen posterior cervical nodes and a red throat. The CBC had a white blood cell count (WBC) of 6,900, with 67% neutrophils, 1% bands, 24% lymphocytes, 3% monocytes, and 5% eosinophils. A repeat EBV antibody profile showed a higher antibody titer than at primary diagnosis. Measurement showed normal levels of IgG, IgM, IgA and IgE. His recovery proved uneventful and he has done well at routine follow-up.

Case 2

A 5½-year-old white male was diagnosed with primary EBV illness with a history of sore throat, sinusitis, URI, abdominal pain, malaise, and fatigue. The diagnosis was based upon physical examination, clinical features, and a CBC with atypical lymphocytes. The EBV antibody profile was positive. He had abdominal pain persist over the following 4 months, then resumption of sore throat and fever. Examination showed tonsillitis. The EBV antibody profile results were lower than the initial screening profile. He recovered uneventfully.

Eight months later he had fever of 39°C, fatigue over 2 weeks, and malaise with sore throat. Examination showed a red throat and swollen posterior cervical lymph nodes. The CBC had a WBC of 6,800 with 66% neutrophils, 9% bands, 18% lymphocytes, and 7% monocytes. A repeat EBV antibody profile was positive with antibody titers

higher than the second screening. Quantitative immunoglobulin levels were normal. He has fully recovered and continues to do well at routine follow-up.

Case 3

A 6½-year-old white female with no previous significant health problems was diagnosed with EBV illness after presenting with symptoms of fever, headache, malaise, fatigue, sore throat, and abdominal pain. The diagnosis was based upon clinical features, physical examination findings, and laboratory results with a CBC with atypical lymphocytes. The EBV antibody profile was positive, confirming the diagnosis. She recovered uneventfully from this episode.

Twenty-three months later she presented with fatigue for 1 month, malaise, sore throat, and recurrent fever of 39.5°C. Physical examination showed a red throat with swollen posterior cervical lymph nodes. The CBC had a WBC of 6,500, with 70% neutrophils, 5% bands, 18% lymphocytes, 6% monocytes, and 1% eosinophils.

The EBV antibody profile was positive with higher titers than noted on the first test results. Quantitative antibody assay showed normal levels of IgG, IgM, IgA, and IgE. She was treated with general supportive measures and is doing well at routine follow-up.

Case 4

A 9½-year-old white female was diagnosed with primary EBV illness with a history of fatigue for several weeks, malaise, headache, sore throat, and fever. Based upon clinical features, physical examination and a CBC with atypical lymphocytes, she was diagnosed with primary Epstein-Barr Virus illness. The diagnosis was confirmed by a positive EBV antibody profile.

She recovered uneventfully and 1 year later had a screening EBV profile showing lower antibody titers. She presented 19 months after primary diagnosis with fever, sore throat, cough, malaise, and fatigue of 1 month duration. Examination showed a red throat and swollen posterior cervical nodes. Diagnosis was confirmed by an EBV antibody profile with antibody titers higher than those found on the second test. IgG, IgM, IgA, and IgE levels were normal. She has fully recovered and does well at routine follow-up.

Case 5

An 11½-year-old white male with sore throat, malaise, fatigue, and fever was diagnosed with

acute EBV illness through a CBC with atypical lymphocytes and a positive EBV antibody profile. He recovered, then 7 months later had an illness with stomachache and fatigue. A repeat EBV antibody profile showed lower antibody titer than at the primary diagnosis.

He returned 8 months later with complaints of fatigue, malaise, sore throat, and stomachache of 1 month duration. There had been no fever. He appeared depressed. Examination showed red throat and sinus drainage. The posterior cervical nodes were palpable. A CBC had a WBC of 6,400 with 47% neutrophils, 46% lymphocytes, 3% monocytes, and 4% eosinophils. Recurrent EBV illness was confirmed by higher EBV antibody titers than that recorded from the second testing. Quantitative antibody levels for IgG, IgM, IgA, and IgE were normal. He continues to be fatigued 1 month after the diagnosis of recurrent EBV illness.

Case 6

An 8-year-old female was diagnosed with EBV illness after presenting with sore throat, fever, malaise, fatigue, and a screening CBC with atypical lymphocytes. The diagnosis was confirmed through a positive EBV antibody profile. She recovered but had several URIs through the following months.

Twelve months after the primary illness, she had an illness with fever at 39°C, sore throat, headache, and cough. Examination showed red throat and palpable posterior cervical adenopathy. The CBC had a WBC of 3,500 with 32% neutrophils, 58% lymphocytes, 5% monocytes, 1% eosinophil, and 4% atypical lymphocytes. The EBV antibody titer 10 days later had higher antibody titers than on primary diagnosis. Symptoms persisted, plus a stomachache, malaise, and fatigue developed. Three weeks after the second profile had been collected a third profile was assayed and showed elevated EA IgG titer. This titer had been negative at the second testing. The child continues 6 weeks after relapse to have sore throat, stomachache, and fatigue.

Discussion

This report reviews six cases of relapsing EBV illness. Even though the number of cases is small, some useful information can be derived from their review. The age range for relapsing EBV was 5½ to 11½ years. No gender difference was noted. Case one had a relapse during the convalescent phase. The other cases had relapse occur after a period

Relapsing Epstein-Barr Virus Illness

of at least 1 year up to 23 months following the primary infection. The child with relapse during convalescence had no fever either during relapse or initial presentation. Except for Case 5, fever was associated with relapses occurring after recovery from primary infection. For Case 6, fever and sore throat first occurred during relapse with fatigue following by several weeks.

The common features of relapse were fatigue, malaise, adenopathy, and sore throat. Symptoms of relapse may occur several weeks to a month before relapse is diagnosed. These features may be only one way relapse may be manifested. Other as yet unidentified symptoms may also occur and produce a different picture for relapse.

Following the antibody titers is helpful for tracking and diagnosing relapsing EBV illness. For Case 3, the higher antibody titers measured at relapse could have been the result of continued antibody production from the initial screening 23 months earlier. High antibody titers may persist after the primary infection. However, her pattern of symptoms with an intercurrent normal period was consistent with relapse in the other children. The other cases had measured lower EBV antibody titers shown between primary EBV illness and relapse. Case 6 was exceptional because she had higher titers at the second testing, but negative early antigen (EA). At a later repeat the EA was positive and confirmed diagnosis of relapse. Increased EA antibody production would be the result of EBV stimulation of the immune system. The complete blood counts were overall non-diagnostic during relapse. Case 6 had atypical lymphocytes present early in the course of relapse. If a CBC had been performed earlier in the onset of the relapse for the other cases, they may also have shown atypical lymphocytes.

The children in this study showed no evidence of immunodeficiency during a relapse. They had normal QIGs and no evidence of underlying immunodeficiency. Patients with congenital or acquired immunodeficiencies usually run a course similar to immunocompetent children. However, they are at a greater risk to develop potentially fatal B lymphomas, severe atypical EBV infections, and EBV-induced or related lymphoproliferative disease. Children immunosuppressed for organ transplantation have increased risk for development of B lymphomas and EBV associated lymphoproliferative disease.¹⁶⁻¹⁸

It is not known if the frequency or pattern of relapses predisposes to lymphoproliferative or other disease. Individuals exhibiting long-standing

EBV infection with high capsid antigen and early antigen antibody titers may be predisposed for African Burkitt lymphoma and undifferentiated nasopharyngeal carcinoma.¹⁹⁻²¹ Extremely high antibody viral capsid early antigen titers have also been found in many patients with persistent or reactivated EBV illness with prolonged pneumonitis, bone marrow aplasia, hepatitis, recurrent febrile episodes, and dysgammaglobulinemias.²²⁻²⁵ Neurologic complications that may occur in these cases are Guillain-Barre syndrome, transverse myelitis, Bell's palsy, and meningoencephalitis.²⁶

Lymphoproliferative disease may develop in these individuals with chronic EBV symptoms.²⁷ EBV DNA is found in the T-cell lymphoma tumor cells. The responding T-cells become infected by the virus and produce malignant transformation.²⁷ However, more typically it is the B lymphocytes that are infected, producing B lymphomas. In a study by Cohen, about one third of non-Hodgkin lymphomas in AIDS patients contained EBV genomes.³² EBV nuclear antigen and viral genomes may be also detected in thymic carcinoma tumor cells.²⁸ EBV may have a role in Hodgkin's lymphoma,²⁵ carcinoma of the parotid gland,²⁹ supraglottic larynx,³⁰ and smooth muscle tumors.³¹

A child who has had primary EBV illness that has recurrent fatigue, malaise, sore throat, and adenopathy warrants rescreening for EBV illness. Epidemiology information continues to be collected that may show the frequency of recurrence, pattern of symptoms of relapse, and potentially triggering events. Improved detection and surveillance methods may help to more clearly define parameters of EBV involvement in EBV induced disease.

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A Daily Devotional

“Ultimately we have to remember that our daily work is a devotional to healing the sick.”

I have been at Jewish Hospital in private practice nearly 6 years and many months prior to that as a resident. I am embarrassed to say that for the innumerable times I have walked through the lobby at this institution, I have never noticed a very lovely mosaic that is present. This mosaic is Maimonide's Prayer. Maimonide was a 12th century physician/philosopher.

This piece caught my eye one morning after an early meeting (which of course had happened to be the usual lackluster event that nearly all of us complain about attending). Luckily I was moved to actually stop and read it. I have a copy of the script below.

Almighty Father of Mercy,
I begin once more my daily work,
Grant that I may be able to devote
myself,
body and soul, to Thy children
who suffer from pain.
In all my efforts to heal the sick,
may I be filled with love for my
fellow man.

This simple, short prayer reminded me of feelings I used to have when I first entered medical school and in particular, when I started clinical rotations as a third and fourth year student. I realize it sounds sappy and just all too ridiculous, but I would venture to say that many of us truly had those feelings when we entered this field. I've seen myself over residency and my years in private practice, as I'm sure many of you have, becoming more and more involved

with administrative details and practice upheavals, and less and less in attending to ourselves and our patients. Realistically, I realize that much of this is unavoidable but I'm very glad that I happened to notice this beautiful piece in the hospital lobby. Ultimately we have to remember that our daily work is a devotional to healing the sick.

There have been many days that I have been unusually frustrated or disappointed to the point where I have considered other opportunities for a career. I think it would be safe to say that many of us have. This has been an unexpected feeling given that I always viewed physicians when I was younger as grand, glorious, omniscient and never doubting their purpose. There have been days it has been a bit scary to realize that I've felt disappointment in my chosen field. Once again, however, I have to remind myself that everyone, in whatever field of study or in whatever occupation, must feel this way at different times. When it all comes out in the wash, I truly love what I do and I can't see myself doing anything else. I believe that this prayer reminded me of those feelings and that purpose.

I believe that the next time I have one of those extremely exasperating days, whether it's arguments with administrators, insurance companies, or just the usual daily frustrations with my schedule, I'll take a quick walk downstairs and focus on Maimonide's Prayer.

Carolyn D. Burns, MD

Everyday Murder

Among the many blessings for which I am grateful, I enjoy a beautiful 23.5 mile drive to and from work each day. It is a quotidian journey to which I am only just now becoming accustomed, having always lived within five miles of school and work. Now I drive each from my home in Lexington to my office in Frankfort, going against the bulk of traffic, yet still finding myself ensconced within a pack of cars, trucks, and other vehicles.

Driving to Versailles and then traveling the additional 10 miles on US60, I am treated to glorious views of horse farms with their statuesque denizens, multicolored sunrises, herds of cattle, a plethora of wildlife, and an ever-changing sky. I've become used to and actually look forward to the drive, as often it is a quiet time in which to catch up on National Public Radio News or just calm down from a hectic day.

On a daily basis, however, I am jarred by several of my fellow commuters speeding by me in a flash. I fancy myself a pragmatic driver; therefore, I often find myself traveling at approximately 10 miles per hour above the posted speed limit of 55, as there are times when to go slower would be to court disaster. All too often, however, my "doors are blown in" by drivers at speeds of up to 90 mph. I look in vain for blue lights to bring the lawbreaker up short, yet most of the time they are not to be seen, in contrast to my college days of 20 years ago when the "boys and girls in blue" were omnipresent. Now, whether because of personnel cuts or answering more urgent calls, one does not see speeders pulled over as often.

I have touched upon this subject in print before,¹ and I fear that some friends and colleagues may feel me to be almost obsessed by the issue of speeders and drunken drivers, but as a medical examiner and forensic pathologist, I obviously see a skewed patient population and have spent the better part of the last decade involved in the investigation of carnage wrought by speeders, drunk drivers, and combinations of the two. Whether a forensic pathologist, family practitioner, internist, surgeon, pediatrician, OB-GYN, or any other type of physician, one cannot help but have patients whose lives have been altered by such drivers, for in 1995, 856 lives were ended and 55,465 people were injured on Kentucky roads.² One in 4,800 Kentuckians died and one in 75 (1.3%) was injured in a motor vehicle collision. Of these injuries, 17% were incapacitating. Twenty five percent of fatal accidents were due to unsafe speed, 20% due to alcohol involvement.

The slaughter on our roads continues, yet with the exception of groups such as Mothers Against Drunk Driving, our citizens and, more astonishingly, we as physicians, interested in the health of the Commonwealth, remain curiously silent on the matter. Occasionally, public wrath is incurred, such as with the recent outcry for murder charges against the Casey County man who allegedly drunkenly drove his truck into a car in Russell County three days before Christmas and killed five people. Murder charges *are* appropriate in such a case, yet what of all the other everyday murders in which a lesser number of people are killed?

Where is our outrage? How is a drunken or recklessly speeding driver different from an individual who indiscriminately fires a gun in a public place, heedless of where his bullets may go? In the former case, the projectile weighs 2000 pounds or so, in the latter, a few grains, but projectiles causing death and destruction are all the same. In our collective, insane rush to go nowhere, we continue to sacrifice lives on the alter of expediency. If any other "product" caused so many deaths and injuries, the outcry from physicians and the public would be deafening.

As physicians and citizens, we should be concerned about and play an integral role in addressing the public health threat of speed and alcohol. Words are powerful: speak to your patients and their families; write to your legislators. We have all been touched at least indirectly by the easily preventable specter of twisted steel and broken glass; now it is time to do something about it.

Gregory J. Davis, MD
Department of Pathology and
Laboratory Medicine
University of Kentucky College
of Medicine

References

1. Davis GJ. Death worship, Carolina style. *NC Med J.* 1996; 57:22.
2. Kentucky Traffic Accident Facts: 1995 Report. Kentucky State Police, Commonwealth of Kentucky.

Professional Volunteers

I would like to talk to you about approximately one thousand professional volunteers working endless hours across the state of Kentucky.

These volunteers call themselves Kentucky Medical Association Alliance members. They come in all ages, from all walks of life and most importantly they are Caring Physicians' Spouses: Partners in Progress for Quality Health Care. They have a common bond. They are physicians' spouses, medical societies across the state. The Medical Alliance forges the relationships among the medical community. The physicians already have that relationship and if you take advantage of the Medical Alliance, you can complete the circle of the extended family.

The strength comes from the numbers. Alliance members are always dealing with issues that affect physicians and their practice or health projects in children's schools or meeting community health needs. One voice can make such a large impact.

These dedicated professional volunteers are making their voice heard under the direction from Kentucky Medical Association and local medical societies across the State. A large number means more than eight county presidents-elect and resident physician/

medical student spouses will be able to attend American Medical Association Alliance's most informative and popular Leadership Confluences I and II.

Leadership Confluences empower our leaders with the knowledge and skill required to be effective leaders in their respective county alliances/ auxiliaries. More numbers of Alliance members means more than four delegates and alternates will attend American Medical Association Alliance's Annual Session/House of Delegates. It also means more votes.

Following are some of the areas in which they are working to help at the Cancer Center: To answer the phone on colorectal testing; helping to immunize the children; screening for scoliosis; demonstrating by candlelight vigil to "Stop America's Violence Everywhere"; coming together to put a tape of different songs together called "Holiday Healing Voices"; putting on Health Fairs; raising funds for the Women's Shelter.

Medical families are at high risk for emotional problems and the Alliance is a support system that is very unique, whether it is belonging to a special interest group, Moms and Tots Play Group or sponsor a spouse, helping young resident physician/ medical student spouses. Working



Aroona Dave

with medical societies, celebrating a success, honoring individuals, observing Doctor's Day, being a PR person to cast a positive image of our doctors and doctors' families.

Our professional volunteers are there serving on school boards, site based decision making councils, mayors, Parent Teachers Association Board, working in coalition with Department of Health Services, Cabinet of Human Resources, Board of Education, Kentucky Action, American Lung Association, Comprehensive School Health Education Committee, and American Cancer Society.

Medical Societies and Medical Alliance working hand in hand, this is a call to each and every spouse of Kentucky Medical Association members. If you believe in your spouse's profession and how he/she is trying to help the families live safer, healthier lives, COME AND JOIN US!!

Aroona Dave
KMAA President
 807 Shamrock Drive
 Madisonville, KY 42431-8646
 502/825-1224

KMA Board of Trustees

The following Officer and Trustees elected in 1996 will be representing their Districts at the 1997 KMA House of Delegates meetings to be held during the Annual Meeting. The House will convene on Monday, September 15, and Wednesday, September 17, at the Hyatt Regency Hotel in Louisville.

Thomas K. Slabaugh, MD, a Lexington urologist, is serving a two-year term as Vice Speaker.

Dr Slabaugh has been an active member of KMA since 1978 and currently serves as Chair of KMA's CME Committee. He has served as a KMA Delegate for Fayette County for several years and is a Past President of the Fayette County Medical Society.

A native of Columbus, Ohio, Dr Slabaugh, 49, earned his undergraduate degree from Washington and Lee University in 1969 and his MD from the University of Virginia in 1973. Postgraduate education included completion of an internship at the University of Virginia Hospital in 1973-74, and a residency in urology at Emory University Hospitals in 1974-78.

Dr Slabaugh is currently serving as Vice Chair of the Board of Directors of Columbia Hospital Lexington and also chairs the hospital's CME Committee. Other hospital affiliations include Saint Joseph Hospital, Central Baptist Hospital, Humana Hospital Lexington, and Columbia Hospital Paris.

Active in community and civic matters, he also serves as an Elder and Chair of the Worship Department at Central Christian Church in Lexington.

Dr Slabaugh's wife, Sugar, shares his involvement in organized medicine. She is a Past Chair of the Fayette County Medical Auxiliary and a past member of the KEMPAC board. The Slabaughs reside in Lexington and have a son and a daughter.



Donald E. Brown, MD, a Somerset general surgeon, is serving as 12th District Trustee.

A member of KMA since 1985, Dr Brown brings several years of experience to this office. His KMA service includes current membership on the Pro Advisory Committee, Delegate from Pulaski County from 1987 to 1995, and Alternate Trustee for the 12th District from 1982 to 1996. He served as President of the Pulaski County Medical Society in 1992. A Fellow of the American College of Surgeons, Dr Brown's other professional involvements include membership in the Society of American Gastrointestinal Endoscopy Surgeons.

A native of El Paso, Texas, Dr Brown, 43, earned his undergraduate degree in 1976 from Centre College in Danville, Kentucky, and his medical degree from the University of Louisville School of Medicine in 1980. He fulfilled a general surgery residency at University of Louisville Affiliated Hospitals in 1980-85.

Dr Brown was Chief of Surgery at Humana Hospital-Lake Cumberland from 1989 to 1990 and Chief of Surgery at Columbia Lake Cumberland Regional Hospital in 1995-96, where he currently serves on the Board of Directors.

He and his wife, Sherry, live in Somerset. They have a son and a daughter.

Thomas E. Bunnell, MD, a Northern Kentucky internist and pulmonary disease specialist, is serving a three-year term as 8th District Trustee.

Dr Bunnell has been an active member of KMA since 1972 and has served as a KMA Delegate for Kenton County since 1986. He is active in community and civic efforts, focusing on the American Cancer Society and Redwood School.

A native of Wisconsin, Dr Bunnell, 56, earned both his undergraduate degree in 1962 and his medical degree in 1965 from the University of Cincinnati. Subsequent education included an internship at Detroit Receiving Hospital, Wayne State University, in 1965-66;

service in the US Navy in 1966-67; residencies in internal medicine at Jewish Hospital, Cincinnati, 1968-69 and the University of Cincinnati, 1969-70; followed by a fellowship in Pulmonary Disease at the University of Cincinnati in 1970-71. He has practiced in Northern Kentucky since 1971.

Dr Bunnell has privileges at St. Elizabeth Medical Center, Covington-Edgewood, and St. Luke Hospital West, Florence. He is affiliated with the courtesy staff at St. Luke Hospital East, Ft Thomas, and is a clinical instructor in the Department of Medicine at the University of Cincinnati.

He and his wife, Nancy, have three sons.



New Officer Profiles

KMA thanks the Vice Speaker and Trustees for their valuable leadership.

John T. Burch, MD, is serving a three-year term as 6th District Trustee.

An orthopedic surgeon, Dr Burch practices in Bowling Green. A native of Florida, he earned his undergraduate degree in 1982 from Western Kentucky University, Bowling Green, and his MD from the University of Kentucky College of Medicine in 1986. Subsequent education included completion of a general surgical internship in 1986-87 and a residency in 1987-91 at the University of Kentucky. In 1989 he completed a fellowship in hand surgery at the Christine M. Kleinert Hand Institute, Louisville.

Active in KMA since 1992, Dr Burch, 38, served as a member of the House of Delegates in 1992-95; mem-

ber, Nominating Committee KMA House of Delegates 1995-96; Alternate Trustee, 6th District, 1995; and was President of the Warren County Medical Society in 1993-94. Other professional involvements include membership in the American Academy of Orthopaedic Surgeons and the Southern Medical Association. Active in civic and community activities, Dr Burch is team physician at Western Kentucky University and is a member of the Bowling Green, Warren County Chamber of Commerce. In 1996, he was listed in "Who's Who in Medicine."

Dr Burch is on the staff of Greenview Regional Medical Center and The Medical Center at Bowling Green. He and his wife, Marla, have three children.



Meredith J. Evans, MD, a general surgeon for 40 years in Middlesboro, is serving a three-year term as 15th District Trustee.

Dr Evans has a long tenure of activity in organized medicine. He has been a member of the Kentucky Medical Association since 1958 and has served as a Delegate from Bell County for several years. He is a member of KMA's Community and Rural Health Committee, and other professional memberships include South-eastern Surgical Congress, Southern Medical Association, and American Society of General Surgeons.

Long active in civic and community affairs, Dr Evans, 70, served 20 years as Chair of the Middlesboro

Independent School Board, 12 years as Mayor Pro Tem of the Middlesboro City Council, and is a Past President of both the Middlesboro Junior Chamber of Commerce and the Middlesboro Chamber of Commerce.

Dr Evans completed his undergraduate studies at the University of Kentucky in 1947 and was awarded a medical degree from the University of Louisville School of Medicine in 1949.

His hospital affiliations include Middlesboro ARH, and Claibore County Hospital in Tazewell, Tennessee.

Dr Evans and his wife, Helen, reside in Middlesboro. They have 4 daughters, 1 son, and 12 grandchildren.

Daniel W. Varga, MD, a Louisville internist, is serving a three-year term as 5th District Trustee.

Dr Varga has been an active KMA member since 1988 and brings several years of experience to his office. He was a Jefferson County delegate to KMA for four years, has served as 5th District Alternate Trustee, and is a member of the KMA Ad Hoc Committee to Develop a Comprehensive School Health Education Plan. Dr Varga is currently serving as President of the Jefferson County Medical Society. A diplomate of the American Board of Internal Medicine, he is also a member of the American Association for the Advancement of Science, American College of Physicians, and the Southern Medical Association.

Dr Varga, 39, attended school in his native Ken-

tucky, earning a BA/BS from the University of Kentucky in 1980 and an MD from the University of Louisville in 1984. His subsequent education included an internship in 1984 and a residency in 1985-86 in internal medicine at the University of Louisville. From July 1986 until June 1987 he was chief medical resident in internal medicine in the Department of Medicine, U of L, where he has been a faculty member since the completion of his residency. He has twice been awarded the Dr Stuart Graves Award for the outstanding clinical teacher. He has served for 5 years on the University of Louisville Medical School Admissions Committee, and organized and still directs the Health Promotion Schools of Excellence Program.

Dr Varga's family includes his spouse, Louisville OB/GYN Kimberly Alumbaugh, MD, and three children.



Board of Trustees Spring Board Meeting

The KMA Board of Trustees met in regular session on April 16-17, 1997, at the KMA Building in Louisville.

Board members heard reports from the President; Secretary-Treasurer; Board of Medical Licensure; Chair, KEMPAC Board of Directors; Senior Delegate to the AMA; Chair, KMA Physicians Plan, Inc; Chair, Kentucky Medical Insurance Company Board of Directors; and the Commissioner, Bureau for Health Services.

The Board adopted the budget for fiscal year 1997-98 and renewed the KMA-endorsed Blue Cross and Blue Shield group insurance plan. In further action, the Board approved the nominees for reelection to the KMIC Board of Directors; appointed the Chair of the KMA Physician Advisory Committee to Health Kentucky; appointed additional members to serve on the Membership Task Force; and selected nominees for service on the Kentucky Board of Medical Licensure and on the Drug Management Review Advisory Board.

Additional reports were given by the Laboratory Advisory Committee, the Committee on Community and Rural Health, the Committee on National Legislative Activities, the Committee on State Legislative Activities, the Public Education Committee, the Ad Hoc Committee on Faculty Membership, and the Committee on Physical Education and Medical Aspects of Sports.

It was noted that HIV and Domestic Violence Seminars will be held on Thursday, September 18, during the 1997 KMA Annual Meeting.

The KMA Board of Trustees will hold its next regular meeting on August 6-7, 1997, at the KMA Building.



Top, ltoR: 5th District Trustee Dan Varga, MD; 9th District Trustee Greg Cooper, MD; VP Don Stephens, MD; President-Elect Ken Peters, MD; President William Mitchell, MD; and Board Chair Harry Carloss, MD. Center: Senior AMA Delegate Don Barton, MD, gave his National Legislative Report as Dr Peters studied the agenda.



Right: State Legislative Chair & AMA Delegate Wally Montgomery, MD, gave a report. ltoR with faces visible, Drs Barton, Goodin, Burch, Farrell, Neel, and President Mitchell.

PEOPLE

Christopher B. Shields MD, is the new chairman of the University of Louisville School of Medicine's neurological surgery department. He was named to succeed **Henry D. Garretson, MD**, who stepped down from the chairman's post after 26 years of service.

Dr Shields, a 1966 graduate of the University of Toronto, did his neurosurgical residency at the University of Manitoba and earned a microvascular surgery fellowship at the University of Vermont.

He joined the U of L faculty in 1974 as an assistant professor of surgery in the neurological surgery division. He became deputy director in 1989 and vice chairman of the newly-formed neurological surgery department in 1994.

Dr Shields has served as president of the Congress of Neurological Surgeons and chairman of that organization's Cerebrovascular Section. He chaired the Task Force on the Decade of the Brain, a joint program of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

With a history of research into spinal cord regeneration, Shields leads a research team focusing on finding a cure for spinal cord injury.

Joan E. Thomas, MD, has been named vice president of the board of the Center for Women and Families in Louisville.

John D. O'Brien, MD, Louisville, has been named to an Ad Hoc Task Force to recommend strategies for the future for the AMA's Organized Medical Staff Section. Dr O'Brien chairs the KMA-OMSS and has been active at national meetings of the AMA-OMSS.

Harold E. Boyer, DMD, recently celebrated his 40th anniversary in

surgical/hospital dentistry at the University of Louisville.

UPDATES

William B. Monnig, MD, Named to AMAP Committee

William B. Monnig, MD, Edgewood, has been named to serve on the Environment of Care Advisory Committee of the American Medical Accreditation Program (AMAP).

AMAP is a new program of the American Medical Association to establish a centralized credentialing process for physicians. The intent is to encourage and assist medical societies and other groups around the country in developing credentials verification organizations which would use standardized criteria to perform credentialing. Physicians would then, hopefully, only have to make application once or a limited number of times for credentialing for medical staff privileges or insurance and managed care plan participation. AMAP would act as the coordinating body for this effort.

To help implement this program the AMAP has formed four committees. Dr Monnig has been named to serve on the Environment of Care Advisory Committee. This group is charged with identifying issues and concerns that physicians might have with the credentialing process being developed and to work with groups interested in becoming accredited by the AMAP.

Dr Monnig is a Past President of KMA and currently serves as an Alternate Delegate to the AMA from KMA.

Physicians Introduce Practice Guidelines to Manage Work-Related Health Problems

Occupational Medicine Practice

Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers was recently published by the American College of Occupational and Environmental Medicine (ACOEM). This 368-page book is the result of a three-year project and was peer reviewed by 120 physicians and health professionals from 13 medically related societies. The book was edited by Dr Jeffrey S. Harris, School of Medicine, University of California, and five physician contributing editors. KMA member **Daniel Wolens, MD**, was one of the contributing editors. *The Occupational Medicine Practice Guidelines* is available, with a 30-day risk-free trial, from OEM Press, telephone: 800/533-8046; or website, <http://www.oempres.com>.

U of L Opens Autism Center

The University of Louisville has been chosen to create and administer the Kentucky Autism Training Center. Authorized by state legislators last year, the center will institute statewide training and education for parents, teachers, and others who work with autistic children. **Peter E. Tanguay, MD**, U of L professor and Ackerly Chair in psychiatry and behavioral sciences, is included among the collaborators for the center.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Augustinus J Lobach MD —FP
3 Kenton Furnace Dr, Ashland 41101
1976, Erasmus U, Netherlands

Bourbon

Richard Murray West MD —IM
6 Linville Dr, Paris 40361
1992, U of Kentucky

Robert A Daniel MD —AN
730 Clintonville Rd, Paris 40361-9172
1991, Med Col of Alabama

Victor G Lawson MD —OTO
24 Clinic Dr Ste B, Paris 40361
1960, U of Toronto

Hardin

Allen Lewis Jr DO —IM
105 Scarlet Oak Cir, Elizabethtown
42701-5540
1993, W Va School of Osteopathic Med

Hopkins

R Scott Wright MD —C
200 Clinic Dr, Madisonville 42431
1989, U of Kentucky

Jefferson

Kimberly Anne Boland MD —PD
1 Audubon Plaza Dr, Louisville 40217
1987, U of Louisville

Paul A Zimmerman MD —C
3914 Therina Wy, Louisville 40241
1988, State U of Syracuse

James G O'Brien MD —FP
201 Abraham Flexner Way Ste 690,
Louisville 40202
1968, U Col of Dublin

Rajendra H Patel MD —IM
290 Laurie Vallee Bldg 14, Louisville
40223-3104
1984, U of Baroda

Thomas Dues MD —IM
8508 Blossom Ln, Louisville 40242
1993, U of Louisville

Lewis

Frances M O'Neil MD —FP
316 Main St Ste 1, Vanceburg 41179
1978, U of Toronto

In-Training**Fayette**

Kimberly L Bell MD —IM
James R Woody II MD —FP

Jefferson

Kerri Simpson Rimmel MD —IM

DEATHS

Frank H. Wight, MD
Owensboro
1925-1997

Frank H. Wight, MD, a retired radiologist, died February 26, 1997. Dr Wight graduated from the University of Louisville School of Medicine in 1952 and was a life member of KMA.

Vester A. Jackson, MD
Paducah
1903-1997

Vester A. Jackson, MD, a retired general surgeon, died March 1, 1997. A 1941 graduate of the University of Louisville School of Medicine, Dr Jackson was a life member of KMA.

Ray H. Hayes, MD
Louisville
1919-1997

Ray H. Hayes, MD, a retired psychiatrist, died March 25, 1997. A 1950 graduate of Georgetown University School of Medicine, Dr Hayes was a life member of KMA.

Sidney E. Farmer, MD
Bowling Green
1924-1997

Sidney E. Farmer, MD, a retired family practitioner, died March 29, 1997. Dr Farmer was a 1947 graduate of the University of Louisville School of Medicine and a life member of KMA.

Michael J. Riesser, MD
Louisville
1947-1997

Michael J. Riesser, MD, an emergency

medicine physician, died April 6, 1997. A 1974 graduate of the University of Cincinnati College of Medicine, Dr Riesser was an active member of KMA.

John R. Gauld, MD
Brandenburg
1928-1997

John R. Gauld, MD, a preventive medicine physician, died April 11, 1997. Dr Gauld graduated from the University of Maryland School of Medicine in 1955 and was an inactive member of KMA.

Neal Calhoun, MD
Hopkinsville
1922-1997

Neal Calhoun, MD, a retired general practitioner, died April 18, 1997. A 1951 graduate of the University of Louisville School of Medicine, Dr Calhoun was a life member of KMA.

Joseph A. Ballard, MD
Lexington
1920-1997

Joseph A. Ballard, MD, a retired otolaryngologist, died April 25, 1997. Dr Ballard was a 1945 graduate of St. Louis University School of Medicine and a life member of KMA.

Benjamin Albert Reid, Sr, MD
Louisville
1908-1997

Benjamin Albert Reid, Sr, MD, a retired general surgeon, died April 26, 1997. Dr Reid graduated from the University of Louisville School of Medicine in 1933 and was a life member of KMA.

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RATES AND DATA

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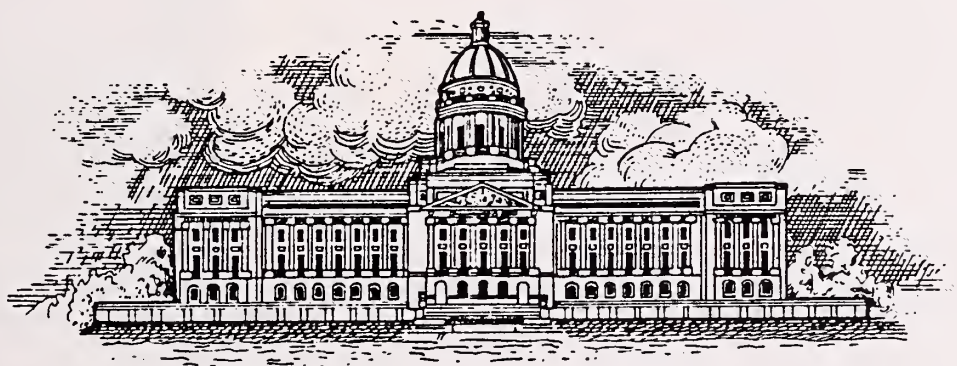
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C. Kenneth Peters, MD.
KMA President 1997-98

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VOLUME 95, NUMBER 10

OCTOBER 1997

COVER STORY	Profile — C. Kenneth Peters, MD, KMA President 1997-98 <i>Sue Tharp</i>	432
SCIENTIFIC	Surgical Management of Intrathoracic Goiter <i>Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle, MD; Craig Nachbauer, MD; Mary Baker, RN, MSN/MHA</i>	421
SPECIAL ARTICLE	25 Years — A Look Back <i>C. William Schmidt</i>	425
SPECIAL COMMUNICATION	Computer Requirements for Medical School Students — Implications for Admissions <i>Carol L. Elam, EdD; Robert F. Rubeck, PhD; Amy V. Blue, PhD; Giulia Bonaminio, PhD; Lois Margaret Nora, MD, JD</i>	429
EDITORIAL	The French Paradox, Confounded <i>A. Evan Overstreet, MD</i>	437
ASSOCIATION	<i>Monitoring Medicine</i> Report of Reference Committee A — AMA House of Delegates August Board of Trustees Meeting News	419 442 445 442
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Classified Information for Authors	413 446 440 447 423



COVER: On September 17, 1997, C. Kenneth Peters, MD, a Jeffersontown family physician, was installed as the 147th President of the Kentucky Medical Association. Dr Peters' Inaugural Presentation begins on page 413 and a profile of this long-time servant of medicine begins on page 432.

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Back to the Future

Inaugural Message C. Kenneth Peters, MD



C. Kenneth Peters, MD

Following is the narrative of a big-screen video presentation prepared by Dr Peters for his inaugural message upon installation as the 147th President of the Kentucky Medical Association.

CKP:

Good Afternoon. I am honored to share with you today. It is a unique time in history for all of us. . . . To borrow from Dickens, both the best and worst of times.

As physicians, we have to master the skill of traversing multiple dimensions of time. We must simultaneously consider a patient's history, assess his or her condition in the present, and help him or her plan for future needs and goals. Likewise, we need to take a page from our own work habits and apply these to how we think about our profession and its role in the post-industrial world. We must learn from the past (without staying in it). We must be active in the present. And we must also simultaneously create a vision for what our future should be—*our future* as a profession and its role in the larger society.

This process must be undertaken collectively. With that goal in mind, I have collected several of our own voices here today to start us on that journey.

As we reflect on our past, we would do well to remember a voice from our past—that of the young reformer, Nathan Davis, who in 1847 at the age of 29 founded the American Medical Association.

Dr Nathan Davis (photo, with voice over)

As physicians, we must have a code of ethics. We have a responsibility to our patients. We have a responsibility to our colleagues. And we have a responsibility to the public.

RESPONSIBILITY TO OUR PATIENTS

Thurmond Coleman

I was very disturbed the day I was going to my physician as always, which I had been going to over 30 years, and all of a sudden I was told that I can no longer go there. Taking away my choice of a physician was very disturbing and caused quite a bit of anxiety. And I do not like that at all . . . I think you ought to have the right to go to whatever physician you want to go to. After 30 years my entire family had to be yanked out, had to go to someone I do not know. Not that I have a problem with that, but it feels strange going somewhere to deal with a doctor who does not know you or your history or anything about your history. Changing over, back and forth, when I believe with all my heart that you have a right to make a choice of your doctor. That is personal. Choice is always important.

Expectations from the Health Care System Today

Bill Faris

Probably the last person you would expect to hear from at a Kentucky Medical Association

meeting would be someone who is an executive in the managed care industry. My company, Occupational Managed Care Alliance, is a managed care provider for Workers Compensation, and when it was brought to me the principles that Nathan Davis had founded the AMA upon, I immediately realized how critical those principles have been in making managed care work in the United States and in Kentucky Workers' Compensation in particular. Managed care doesn't work because of utilization review; it doesn't work because of people keeping track of one another. It works because physicians have agreed to participate in it and physicians have agreed to lend their expertise and their cooperative effort to making it work. And in the three areas to which Nathan Davis referred—physicians' relationship to community, physicians' relationship to patient and physicians' relationship to one another—those three items encompass everything that we do in managed care. Physicians obviously make managed care work by relating well and treating well and lending their expertise to their patients. They clearly make managed care work by relating to one another and developing a continuity of care as patients move through the occupational medicine system. And by doing those two things, they specifically relate to their community. By helping injured workers get back to work as soon as possible, by helping them be more productive, by helping business climate improve, and by keeping health costs down for all of us.

Rosalee Farris

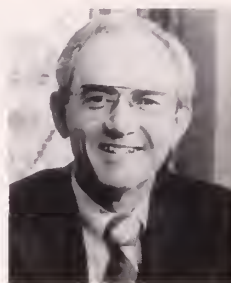
As a nurse, I bring to the patient role a totally different perspective than most patients. The issue that we deal with as nurses is sometimes that we want our physician to treat us the way we want to be treated, and sometimes that is not a realistic expectation. What I'm looking for when I select a physician is someone who will listen to what I have to say, who will spend time with me, who will give me the attention that I need, and also understand that as a nurse I may not have an unbiased opinion about my own health condition. So what I want is a physician who will talk with me as if I were not a nurse and who will listen to what I have to say and listen to what is going on within my system and give me direction and treat me appropriately. I expect as always the professional courtesy of a co-worker because the relationship that I may be in at that time as patient may be totally different the next day. The next day I may also see that physician in the hallway at the hospital and be relating to him on a more personal level as opposed to a patient level.

CKP:

Sometimes it seems difficult to work directly with patients on their goals because of the complex array of players involved in managed health care today. The growth of managed care in the US is now legendary. Ninety-one million Americans are now enrolled in PPOs, while almost 59 million belong to HMOs. Although it sometimes seems as though there are 149 million different managed care plans, they are all fundamentally concerned with basic issues of access, resource utilization, cost, quality and outcomes. These concerns are the same ones physicians like Nathan Davis were trying to balance 150 years ago. Like Davis, we have to take charge of redefining our role to meet the challenge of the times.

We have lived through the upheaval of the transformation to managed care and have fought to maintain the focus on our responsibility to the patient. We now must move from our individual responses to the managed care phenomena to collective and proactive participation in shaping our new environment.

One key initiative we are committed to in the coming months is the development of our own statewide PPO.



Dr Bob Goodin — Update on PPO Progress and the Importance of the Initiative

Today the public as well as all health care providers realize that we are in the middle of a major transition in the way health care is delivered in this country. It seems to me that all providers are vulnerable at a time like this, but I think the group that's most vulnerable are our patients. I think we physicians need to be most concerned for that group of people. You know, this change has been fueled not by deficiency in the quality of health care, but by cost concerns. It's only been a few years since patients could really rely on their hospital or their insurance company to have their best interests as a first priority. We all know that's changed today, and I believe that physicians are the only real advocates that patients have left to count on. I'm afraid we physicians have found ourselves too busy taking care of patients and have somehow neglected our rightful duties as captains of the healthcare delivery team. One way that we can regain that deserved leadership role in healthcare delivery is for physicians to own and operate their own managed care organization. Your Kentucky Medical Association Physician Plan is just that. We are developing this plan so that physicians can have a strong unified voice in medicine and we need to be directing the healthcare in this state. I would contend that only physicians should decide what benefits are essential and in what areas costs can be safely reduced. We would hope to have our plan of a statewide network of providers fully operational by July 1, 1998. And I would really urge all of you to join this network and to support it because we will need your support in order to succeed and to represent you, our physicians.

CKP:

In addition to our own efforts, we have a number of allies in our push for greater balance and better quality in managed care. Major employers have recognized the need to push for appropriate access and quality,

greater standardization of processes, and a more thoughtful approach to cost management. These purchasers, who include such familiar names as UPS and Ford, are the prime force behind the National Committee for Quality Assurance (NCQA), whose mission is to accredit managed care organizations across the country and raise the bar of performance. At the start of 1997, more than half of all the HMOs in the country were already in the process of seeking NCQA accreditation. Thirty-five percent of a plan's score relates to quality improvement activities, including service to its members and attention to quality of care. Accreditation also focuses on member rights, preventative health services, physician credentials, utilization management, and medical records.

While these efforts may mean more work for some of us in the short run, they are good news for all of us in the long run. I expect that the moniker NCQA will become as familiar to those of us in the outpatient world as JCAHO has been to the hospital world. NCQA is increasingly required or requested by major purchasers and no health plan will be able to succeed in this process without working more collaboratively with its physicians on issues that concern us all.

As we work within the system to improve it, we must also pay attention to important trends taking place outside the conventional health care environment. In 1993, the *New England Journal of Medicine* reported a startling fact that has gone unheeded by many of us—that 3 out of 10 Americans pay out of their own pockets for a range of alternative health care therapies. Already, such nationally recognized health plans as Oxford are incorporating "alternative" coverage into their insurance offerings. Clearly, these are signals that our patients believe some important needs are going unmet. I believe we have a clear responsibility as a profession to listen to our patients and educate ourselves on these issues so that we can serve as their advocate. We must be open to those strategies which are safe and effective but exercise due diligence for those which are fraudulent or hazardous. The good news in these trends is that patients are taking a greater interest in their own health, and as such, are better partners in health promotion.

RESPONSIBILITY TO EACH OTHER**CKP:**

In order to rise to the challenges before us,

we need everyone in our profession at the table, with all their gifts and graces. The complexity of change calls for "all hands on deck" in organized medicine. Moreover, we cannot effectively represent the diverse interests of our patients unless our profession reflects that diversity—in terms of gender, race, ethnicity, and age.



Dr Ardis Hoven — On Inclusiveness

As medicine is changing in many ways, it is readily apparent that the Kentucky Medical Association needs to take a very strong look at what we are about, who we are, and what we are doing. Clearly, membership in the Kentucky Medical Association is a very important part of being a physician in the state, and with it goes a lot of responsibility. Those responsibilities now ask us to look at including all practices, all types of practices, all genders, everyone who is interested in taking care of patients. The Kentucky Medical Association should in fact not only speak for physicians, but in fact speak for the house of medicine and particularly maintaining a very strong relationship between the physician and the patient. It is with that in mind that we as physicians need to begin looking at what we really want to do with organized medicine. We wish to be proactive, we wish to be inclusive, we wish to be very, very active in new things, new occupations, new ways of practicing medicine, and new ways of taking care of our patients. And with that, we want to look very seriously at who we are and how we are going to go about doing it. Membership in KMA is an honor. It is a responsibility at the same time. And I think it is very important that we in the future look very critically at how and what we are going to be doing in organized medicine.

CKP:

In order to involve as many physicians as possible, we must reach out to our youngest physicians and provide meaningful opportunities for their participation from student and residency days.



Amy Waltrip — Student Representative to KMA Board of Trustees

In medicine today, we need to learn not only how to diagnose and treat disease—we need to learn how to work together to advocate the rights of our patients and to insure their safety and well-being. The Kentucky Medical Association has offered me many opportunities to learn to acquire these traits. First of all, they offer many opportunities for leadership. I'm involved in their Annual Meetings, I'm involved in the Legislative Committee, I'm also involved in their Board of Trustees. They always welcome students; they always genuinely welcome student input. Anything that I have to say, they're there to listen, they're there to help. Usually, at a Board meeting, someone will come up to me and say, "Amy, if there's anything you need . . . if you want us to come speak to the students . . . if you need any helpful advice . . . we're here for you, so just give us a call." They also advocate our rights. It would seem as if Kentucky Medical Association Board members are advocating things for the state, things about Medicare, things that we don't think about as much as students. But really they're out there working statewide and nationwide to insure our loans, insure our education, and we need to support the people who are out there advocating our rights.

CKP:

In addition, we must keep our perspective broad when thinking of who our colleagues are. The medicine of the present and the future is a multi-disciplinary team effort—physicians have a unique role but must think in terms of connections and systems.

We are all honored to practice in our great Commonwealth of Kentucky, and as such, we must be mindful that we are both urban and rural, mountain and farm, suburb and small town. Our needs may be greater, lesser, or equal depending on the concern. Many of our roots are from rural Kentucky, as are mine. We must never be so preoccupied by our urban strategies that we lose sight of our rural colleagues' present needs.



Dr E.D. Roberts — Chair, Rural Caucus

Realizing that over 50% of physicians practicing in Kentucky are located in rural areas, the KMA through its House of Delegates and Board of Trustees has always been sensitive to the needs and concerns of rural physicians. For over 50 years, the KMA sponsored the Rural Medical Scholarship Fund, and has helped young physicians financially during their training and in finding suitable practice locations. Several years ago, the KMA Rural Caucus was formed to give rural physicians an organized voice in KMA affairs. And in the last few years, the caucus has seated as many or more delegates than those representing urban areas. If you practice medicine in rural Kentucky, you can be assured you have a voice in the KMA.

RESPONSIBILITY TO THE PUBLIC

CKP:

As we approach the 21st century, we face extraordinary ethical challenges—some new, some old—that require the attention and leadership of our profession. Regardless of our specialty, each one of us will confront the implications of genetic testing for vulnerability to illness in our practices. The Human Genome Project is this generation's Manhattan Project, and much like that earlier endeavor, the science is coming faster than the wisdom about how it may be applied. Merely printing out the 3 billion DNA base pairs to be found in a single human cell would fill 16 sets of the *Encyclopedia Britannica*. Yet we lack even the briefest guide for how we should proceed to utilize this wealth of information. Mapping of the genetic frontier lays bare the most basic and personal components of our patients' lives—offering both the potential for new benefits and unforeseen risks. We must begin a serious public dialogue about how we collectively hope to use this wonderful new technology while safeguarding everyone's critical need for confidentiality, privacy, and respect. To

remain silent as a profession in this debate is to surrender the essence of the doctor-patient partnership for decision making.

In addition to the sheer explosion of new medical information, we are also in the middle of a revolution of how we manage information of all types. Where once our major concerns might have been learning to write legibly or finding an answering service, we now have the potential to harness unlimited modes of communication through the Internet, videoconferencing, and other mechanisms not yet fully imagined.

As a profession, we need to harness these tools to better serve our patients—making it easier for them to communicate with us, for us to communicate with each other, and for all of us to stay on top of the latest resources and research. In addition, we must be active in ensuring that these technologies are used wisely, that they can help us keep costs down in the long run, and that patient confidentiality is not compromised.

We continue to be called by the public for reflection upon and guidance about other areas of technology as well, especially as technology pertains to the end of life. The persistence of litigation in these sensitive areas, the unresolved questions about assisted suicide, the resurgence of interest in spirituality, and the daily struggle to help our patients and families manage the process of dying—all of these amply demonstrate societal conflicts about the end of life.



Dr Harry Carloss — End of Life Issues

Physicians have a sworn duty to treat illness, relieve suffering, and sustain life. The well-being of each individual patient supercedes the needs of society or the burden to the family. These decisions should be based on the quality of life. Patient desires must be strongly considered. Those with terminal conditions should be counseled by their physicians. Hospice programs, living wills, and other such things should be discussed

freely. This will help prepare the patient and the family and improve the quality of life and the dignity of death.

In these situations, the physician's duty to sustain life and relieve suffering sometimes come into conflict. In these instances, the patient's wishes should be paramount in consideration of action. A patient's decision to forego life-sustaining treatment should be respected. Life-sustaining treatment includes mechanical ventilation, renal dialysis, chemotherapy, hydration, nutrition, and antibiotic support. There is no ethical distinction between withholding or withdrawing life-sustaining treatments.

This does not, however, include physician assisted suicide, which remains a crime in most states. In countries where physician-assisted suicide is legal, on retrospective review, 28% of the cases do not meet the strict guidelines laid down by the governing agencies prior to the institution of these laws. This reinforces the concept of the slippery slope in assisted suicide. However, physicians do have the responsibility to provide palliative care even if it may hasten death. Courts and other regulatory agencies recognize the difference between use of narcotic drugs in terminal situations and in other situations of life.

This being said, the physician must consider the cost of health care interventions to society as well as his or her individual patients. In our society, there is a finite amount of money present for health care. If we waste or abuse these monies, society suffers. An example of this would be home health care. Home health care is a wonderful thing providing assistance to people who cannot live in their own surroundings unaided. However, its injudicious use in the past several years has added billions of dollars to the healthcare budget, causing budget shortfalls for other medical necessities. It has been estimated that 10 to 30% of Medicare dollars are spent in the last few days of life. Care rendered in all situations must be effective clinically as well as cost effective.

Recently, the automakers have led the way in showing us how to practice cost-effective medicine. They sent a team of productivity experts to Wayne State University Cancer Center. They were able to achieve a 30 to 50% increase in productivity without affecting patient outcomes or quality of care. They further studied the cost variation from plant to plant. It costs 79% more to treat the patients in Kokomo than it does

to treat the patients in Syracuse. We must help to find out why these cost differences exist and eliminate them. If we do not, others who care less about patient quality of care and patients' rights will be making the rules.

CKP:

Our credibility to provide leadership in all these critical areas rests not only on our individual skills and professional knowledge, but on the public's trust in our collective stewardship. Continued commitment to public service is essential to that public trust. I want to congratulate all of you who have helped to make our Kentucky Access program a successful role model for the country.

On a more personal note, I want to commend the work of our physicians with the Jefferson County Medical Society in carrying on Father Morgan's lifelong commitment to the homeless through the Healing Place, which recently celebrated the expansion of additional services including classrooms, meeting place for AA, a chapel, 35 handicap accessible apartments, plus additional space for homeless, addicted women.

I look forward to sharing more stories of our service around the state in the coming year.

Our work in our communities is also greatly enhanced by the KMA Alliance. As our partners, their programs address needs of our families and communities that will affect the future of us all.



Aroona Dave — KMAA President

The Kentucky Medical Association Alliance is the volunteer voice of the Kentucky Medical Association. It promotes the good health of the Commonwealth of Kentucky and is a support group for the family of medicine. In our counties, caring physician spouses organize different health related programs, raise funds to purchase and provide AMA Alliance's publications, HIV/AIDS posters in

the schools, raise more than \$65,000 for medical education and research, and advocate sound health in medical legislation. In 1995, Kentucky Medical Association Alliance joined AMA Alliance's campaign against violence, SAVE, which is an acronym for "Stop America's Violence Everywhere." Today, almost all the organized medical alliances/auxillaries' counties have programs to assist victims of violence, teach children conflict resolution skills, and educate the public about violence prevention. And we are using "Hands Are Not for Hitting"—these are the placemats for K-3 children in the schools, and "I Can Choose" coloring booklets—these two come with teacher instructions. Both of them address conflict resolution. These days, our membership is changing. Members come from all walks of life. They are career spouses, male spouses, they are from here as well as foreign-born spouses.

CKP:

Finally, our effectiveness in the public sphere is inextricably linked to our participation in the legislative process. We must have a strong political action strategy to be a player in the planning for the 21st century.



**Dr Wally Montgomery —
Legislative Agenda**

Please feel free as members of the House of Delegates of KMA and also as physicians who are licensed to practice in this state to contact your KMA leadership, to contact your legislative chairman and other people on the Legislative Committee and the Quick Action Committee, that we may respond to your concerns as we gear up and plan for the next session of the Kentucky General Assembly. Be assured that on a weekly basis you will receive bulletins, you will receive a Legislative Handbook sometime in January, and we need you to stay involved. We expect and want every physician in this state, every member of KMA to be a key contact. Know your legislator, know your representative, and

senator. Make sure that you let them know what is going on in Frankfort and that you have some effort and some interest in seeing that things are done right and according to what we know is in the best interest of the physicians and the citizens of the state of Kentucky.

We do know that we want to have a Patient Protection Act. We have introduced this twice. The Attorney General is going along with this Act this time and is helping us. We do hope we get a favorable hearing from the Governor and some help from the Lt. Governor for this very important Act for the citizens of the state.



Dr Bill Monnig — KEMPAC

We see this as a great opportunity this year for the individual members of the medical community to support the political action activities of KEMPAC. There probably hasn't ever been a year where more people are being elected to office that would have a direct impact on health care than the year 1998. We will be electing one of two senators, all of the house of representatives at the federal level, all of the house of representatives at the state level, and half of the senators. The issues of healthcare reform are going to continue to be a major item for the state legislature and the federal government. The best way an individual physician can participate in this process is by joining KEMPAC. We look forward to your participation, we need your help, and we demonstrated back in 1994, when we all recognized a crisis, thinking that national health insurance was going to be here and state health insurance was going to be here, that we can make a difference. It's important to pay your dues, to become an active participant. This is a bipartisan effort. We need physicians, we need the spouses, we need the help of everyone who is directly affiliated with healthcare and physician services to be active in KEMPAC. A very few people have carried the major burden of KEMPAC in the past. We ask

for your support, and we certainly look forward to supporting Ken in his efforts this year.

CKP:

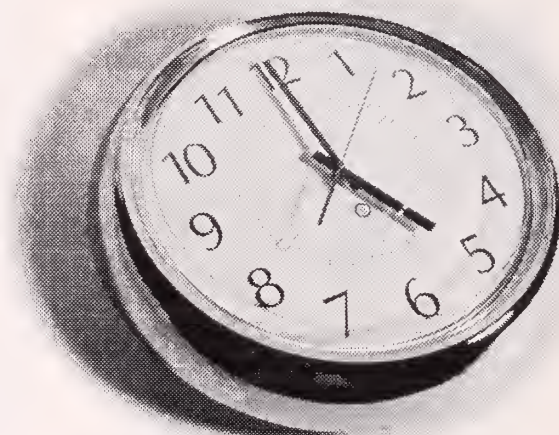
We are very fortunate in the Kentucky Medical Association to have a team that is active in shaping our present so that it positions us for a productive future. Here is a snapshot of the collective talents who will make this future possible. . . .

(Shots of Trustees, members, staff and support personnel)

As we look back 150 years, the world in which that young rebel reformer, Nathan Davis, founded the AMA, seems very quaint to us and the resources for healing very limited. If we are able to project ahead 150 years to the year 2147, in all probability our world of science and technology that seems so advanced to us will seem very quaint to them and our resources for healing rather primitive. The ethical foundation from which Davis worked—living out our responsibility to our patients, to our colleagues and to our communities—will be as solid a foundation in 2147 as it was in 1847 and is in 1997.

Sometimes in the rapidly changing era of modern health care, we feel a sense of loss of control. It is my firm conviction that if all of us in Kentucky medicine bring our gifts to the table and invest ourselves in the well-being of our patients, our colleagues, and our communities, we will impact both the reality of the present and the shape of the future.

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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

Patient Protection and Preservation of Choice

The 1995 KMA House of Delegates adopted Resolution H — Patient Protection — which directed KMA to develop patient protection legislation. In 1996 the KMA House of Delegates established patient protection as a “legislative priority” of KMA. Since that time we have worked with Representative Bob Damron, Jessamine County, and Past KMA President, Representative Bob M. DeWeese, Jefferson County, to develop patient protection legislation. In addition, we have worked with Attorney General Ben Chandler who developed a “patient’s right to know” proposal which has since been fine-tuned by Representatives Damron and DeWeese into their patient protection package.

Patient Information from Insurers

Requires all insurers to state, in writing, the conditions, terms and information, such as appeals mechanisms; prior authorization; restrictions on access to providers; and other review mechanisms imposed by the insurer.

Financial Disclosure by Managed Care to Patients

Managed care plans must include lists of physicians, by county, specialty and hospital affiliation, disclosing any financial incentives from the managed care plan or other appropriate consumer information.

Patient Assurance That Adequate Staffing Exists

Requires all managed care plans to have sufficient numbers of primary care, specialist providers, and facility access. Telephone access must be available 24 hours to the plan, and

reasonable standards must be established for waiting times to obtain appointments.

Choice of Providers/Right to Use Specialist as Primary Provider

Patients choose their primary care provider from a plan list. Plans must permit patients to use specialists as a primary provider when medical conditions warrant.

Definition of Emergency Care That Layperson Understands

Emergency care must be available without prior authorization, and a definition must be established which a reasonable layperson understands.

Patient Choice

Patients must have adequate choice among participating providers, and enrollees may choose their own primary care providers from the plan list. Plans must permit enrollees to use a specialist as a primary provider when medical condition warrants.

Prohibition of Gag Clauses

Prohibits managed care from limiting providers disclosure to patients of medical conditions or treatment options.

Provider Termination by Managed Care

Each plan must have a policy governing de-selection or termination of a provider from a network. If requested by the provider, the network must provide a reason for termination and hold a hearing within 30 days.

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Surgical Management of Intrathoracic Goiter

Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle, MD; Craig Nachbauer, MD; Mary Baker, RN, MSN/MHA

Intrathoracic goiter is a rare clinical entity. This goiter can develop slowly and the patient may be asymptomatic for many years. A significant number of these patients, however, may develop various complications as a result of compression of vital structures or malignancy. In this report, the surgical management of 18 cases of intrathoracic goiter are reviewed. Six of the patients underwent right thoracotomy with resection of the posterior mediastinal goiter. The remaining 12 patients had their tumor removed via median sternotomy. There were no surgical deaths within this series.

Although the incidence of intrathoracic tumor is limited, the threat of malignancy and compressive symptoms clearly indicates the need for surgical excision. Our group recommends thoracotomy and median sternotomy for surgical excision.

Intrathoracic goiter is a rare clinical entity. This goiter can develop slowly and the patient may be asymptomatic for many years.^{1,2,3} A significant number of these patients, however, may develop various complications as a result of compression of vital structures.^{2,4} The primary areas of compression include the trachea, esophagus, superior vena cava, and other neighboring structures. In this report, we present clinical features and surgical management of 18 cases of intrathoracic goiter.

Materials & Methods

A retrospective review was conducted on 18 patients with intrathoracic goiter. Ages ranged between 37 and 80 years. There were 6 men and 12 women in this series. Four of the patients were asymptomatic and referred for evaluation of abnormal x-ray findings. The remainder of the patients presented with a broad range of symptoms, including shortness of breath, dysphagia, dry cough, and respiratory failure. Two of the patients had undergone previous thyroidectomy. Diag-

nostic studies included chest x-ray, tomography, radionuclide scanning, computed tomography (CT), esophagogram, thyroid function tests, and endoscopy. The accuracy of preoperative diagnostic studies varied (Table 1).

Results

All of the patients within the series underwent surgical resection under general anesthesia. Six of the patients underwent right thoracotomy with resection of the posterior mediastinal goiter. The remaining 12 patients had their tumor removed via median sternotomy. One of the patients who underwent median sternotomy also had coronary artery bypass surgery performed. Complications within this series included respiratory distress (1), suture granuloma (1), and transient hypocalcemia (2). There were no surgical deaths within this series. Follow-up ranged from 1 to 20 years with all patients doing well. All lesions revealed multinodular adenomatous goiter. Average specimen weight was 138 grams with a range from 40 to 305 grams.

Discussion

The terms substernal and intrathoracic goiter are often considered synonymous. Three categories of intrathoracic goiter are described in the literature: substernal, partial intrathoracic, and complete intrathoracic.⁵ A substernal goiter is comprised of

From the Division of Thoracic & Cardiovascular Surgery, Central Baptist Hospital, Lexington, KY.

Table 1: Accuracy of Preoperative Diagnostic Studies

Diagnostic Study	Percent of Accuracy
Chest X-ray	50%
Thyroid Scan	50%
Tomogram	38%
Computed Tomography	75%

Surgical Management of Intrathoracic Goiter

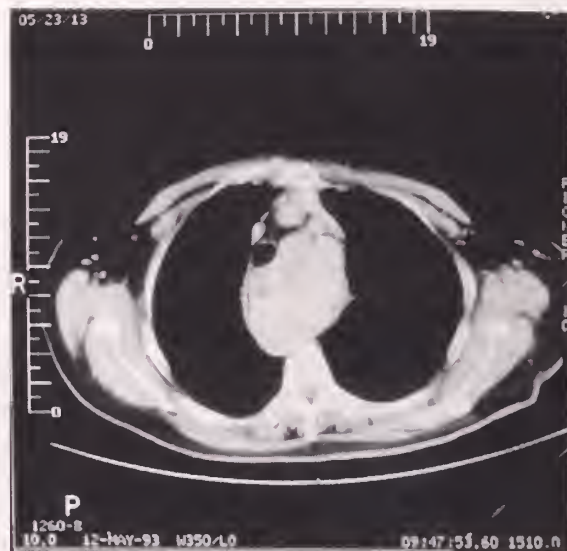


Fig 1 — CT scan showing posterior mediastinal mass.

the cervical thyroid with a segment of the enlarged gland extending into the mediastinum, beyond the thoracic inlet. Partial intrathoracic goiter has been used to describe glands where 50% or more of the mass resides in the chest. In addition, a significant cervical component is present in partial intrathoracic goiters. Complete intrathoracic goiters, however, have an absent or extremely limited cervical component and are typically seen in elderly patients. Data suggests that advanced age contributes to the descent of a cervical thyroid into the chest.⁶ Mechanisms which are thought to aid in the process of descent include deglutition, gravity, and negative pressures.^{7,8} Rarely, this process could be due to enlargement of biologically aberrant thyroid tissue.

The anterior thoracic goiter or retro sternal intrathoracic goiter usually arises from the lower poles of the lateral lobe or the isthmus. The posterior goiter usually originates from the posterolateral aspect of the lateral lobes. The overwhelming majority of patients present with respiratory symptoms, although they may also develop dysphagia or manifest venous obstruction. The CT scan (Fig 1) appears to be the most reliable noninvasive diagnostic study.^{2,6} Characteristic findings associated with CT include clear continuity with the cervical thyroid gland, nonhomogeneity often with discrete nonenhancing low density areas and well defined borders.⁹ Calcifications may appear punctate, coarse, or ringlike. Attenuation values obtained precontrast may be at

least 15 Hounsfield (H) units greater than adjacent muscles. Attenuation values following contrast enhancement may be more than 25 H units greater than adjacent muscles. Typical patterns of goiter extension into the mediastinum may also be observed. Thyroid scan, although performed often, provides an accuracy rate of approximately 50%. This is primarily due to the fact that the goiterous tissue fails to pick up radioactive trace or elements. It should also be noted that a patient can have thyroid elements in a teratoma and could confuse their diagnosis. A definitive diagnosis is established by the operative procedure. Preoperative differential diagnosis may include thymoma, lymphoma, congenital cyst, aneurysm, intrathoracic lipoma, teratoma, and neurogenic tumor.^{3,10,11}

Intrathoracic goiter is a space-occupying lesion and prone to develop multiple complications, including airway obstruction, esophageal obstruction, venous obstruction, infection abscess formation, thyroid toxicity, and malignancy. The incidence of malignancy associated with intrathoracic goiter has been reported up to 16%.⁴ Venous obstruction, however, is rarely observed.

Conclusion

In an effort to establish a definitive diagnosis and prevent complications, surgical removal of these lesions is recommended.^{1,2,6} The procedure of choice within our group is determined by site in an effort to enhance exposure for complete removal of the mass. Median sternotomy is recommended for the retrosternal goiter or anterior mediastinal intrathoracic goiter. Right thoracotomy is recommended for removal of the posterior goiter.

Many reports within the literature recommend cervical excision and removal of the tumor by spoon or morcellation. Our group remains concerned regarding tumor disbursement and uncontrolled bleeding during the procedure of morcellation. In addition, many of these large masses or cysts could result in serious venous injury due to accessory venous drainage to the innominate vein. We recommend, therefore, that operative therapy should be offered to these patients to establish a definitive tissue diagnosis, relieve symptoms, and prevent complications.

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25 Years – A Look Back

C. William Schmidt

Twenty-five years ago the Kentucky Board of Medical Licensure was created as a result of legislation passed by the 1972 Kentucky General Assembly. Prior to that time, all medical and osteopathic licensure was handled by the Kentucky Department of Health. In 1972 an independent board was created to handle all medical licensure matters. Its office was moved from Frankfort to Louisville and its first Board meeting was held in September of that same year. From its humble beginning, the Board has grown and matured into one of the finest medical boards in the country. In recent years, the Board has been recognized by a national consumer group as one of the top medical boards in the country in taking disciplinary action against physicians who violate the Medical Practice Act. The accomplishments of the Board over the past 25 years are well documented in its annual reports to the Governor.

The Board's existence began at the KMA Building in Louisville with three full time employees. During its early stages, the Board's office basically handled applications for medical and osteopathic licenses and had no investigative or legal staff. The State Department of Health provided investigative assistance on a part-time basis. In the early years, the Board employed two part-time attorneys to handle its legal needs. At that time, disciplinary action against physicians was at a minimum primarily because the Medical Practice Act limited the Board's disciplinary authority.

Until the creation of the Board, all administrative costs for medical licensure were paid by the State Department of Health's operating budget. Since the Board received no money from the state budget it needed to generate its own operating funds, so in 1973 the Board initiated an annual registration fee of \$12. All physicians holding a Kentucky medical license who wished to keep their license current were required to pay this fee. This income was used to generate funds to help cover the administrative costs of running the day-to-day operations of the Board office.

The original Board consisted of eight medical physicians and one osteopathic physician ap-

pointed by the Governor. Over the years the Board has been increased on two occasions and is currently comprised of 13 members, including two consumer representatives. The first consumer representative was appointed in 1977. The Board has had three presidents since it was created. The first President was William T. McElwain, MD, Frankfort, followed by John C. Quertermous, MD, Murray, and the current President, Royce E. Dawson, MD, Owensboro, who has served on the Board since its beginning. Consumer representatives have included Vivian Turner, Burl Mack, Cornelia Serpell, and Edward Ashcraft. Kathie Grisham and Dorothy Newberry currently serve as the consumer representatives. Other physicians who have served on the Board include David T. Allen, MD; Walter S. Brewer, MD; D. Kay Clawson, MD; Charles L. Conley, DO; Bernard B. Dailey, DO; Frank M. Gaines, Jr, MD; Stanley Hammons, MD; Calixto Hernandez, MD; Booker T. Holmes, MD; Arthur H. Keeney, MD; John S. Llewellyn, MD; T.C. McDaniel, DO; Olney M. Patrick, MD; Robin D. Powell, MD; Richard H. Swigart, PhD; and Gerard A. Weigel, MD.

In 1982 a series of articles appeared in the *Louisville Courier Journal* charging the Board with not carrying out its statutory responsibilities to protect the public from physicians who violate the Medical Practice Act. This was attributed in part to lack of personnel and operating funds. In order to increase personnel the Board needed to increase its income, therefore it decided to raise the physician annual registration fee to \$35. The additional income allowed the Board to employ a full time attorney to handle its legal needs and two full time investigators to handle complaints filed against physicians practicing in the state. During the next two years, the Board's administrative staff was more than doubled in an effort to carry out its statutory responsibilities.

That same year, in an effort to handle complaints filed against physicians more effectively, the Board established a disciplinary review committee. This committee was known as the Physician Review Advisory Committee, chaired by Walter I. Hume, MD, of Louisville. This committee provided val-

Mr Schmidt is Executive Director of the Kentucky Board of Medical Licensure.

25 Years — A Look Back

uable assistance to the Board for four years. This committee was dissolved in 1986 when the Medical Practice Act was amended, establishing two Board disciplinary panels to take over these responsibilities. Also that year, the Board was increased to 11 members.

In 1983 major changes in the Medical Practice Act were proposed by the Board, and with the help of the KMA, these changes were approved by the 1984 Kentucky General Assembly. The changes strengthened the authority of the Board and allowed it to take the necessary disciplinary actions against physicians who violated the Medical Practice Act. Through the years the Board continued to enhance its disciplinary and investigatory process.

Since 1983 the Board has published its own newsletter. This publication is sent to all physicians maintaining a current medical license. The newsletter is published quarterly and has proven to be a very useful means of communication and has served as an excellent educational tool. The newsletter calls attention to statute and regulation changes, adoption of new guidelines, and disciplinary action taken against physicians who have violated the Medical Practice Act. It is also used to help clarify issues regarding policies of the Board, its role, and how it conducts business.

The Board's statutory responsibilities have increased over the years. Originally the Board regulated only the practice of medicine and osteopathy in the state. In 1978 the Kentucky General Assembly gave the Board the responsibility to regulate paramedics and athletic trainers in the state. That same year a Paramedic Advisory Committee and State Council on Athletic Trainers were established to assist the Board in carrying out these day-to-day administrative responsibilities. In 1988 the legislature added the responsibility of regulating physician assistants in the state. Today the Board continues to regulate these professions.

The number of physicians practicing in the state has steadily risen since the Board was founded. In 1973, 3717 physicians renewed their license. At the present time, 7389 physicians practice in the state and another 3151 practicing outside the state maintain their Kentucky medical licenses. This represents almost a 100% increase in the number of physicians practicing in the state within the past 25 years.

The Board's legal needs have grown over the years. As noted earlier in this report, in its early stages, the Board used private attorneys on a part-time basis. The Board originally employed a part-

time general counsel and a part-time hearing officer who heard cases involving charges brought by the Board against physicians who violated the Medical Practice Act. In 1988 the state Attorney General's Office began providing hearing officers to the Board. As its legal needs increased the Board found it necessary to employ its own full time attorney. In recent years, the Board's Legal Department has employed law clerks and paralegals to assist in its day-to-day legal needs. The legal department today provides expert legal advice to the Board.

The state medical examination is administered twice a year to qualified medical and osteopathic graduates seeking licensure in the state. In 1992 the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB) introduced the United States Medical Licensing Examination (USMLE). Prior to this time, most US and Canadian graduates took the NBME examination and all international graduates took the Federation Licensing Examination (FLEX). Today a single examination is given to all medical graduates seeking licensure. This provides a common evaluation system for all applicants for medical licensure.

In 1994 the Board implemented a regulation requiring all physicians wanting to maintain their Kentucky medical or osteopathic license to obtain 60 hours of continuing medical education every three years. By statute, two hours must be acquired in an approved HIV/AIDS course. Individual audits will be made requiring physicians to submit proof of obtaining the appropriate CME credits during the allotted time.

During the 1994 Kentucky General Assembly amendments were passed to the Medical Practice Act which in part authorized the Board to establish an impaired physicians program in the state. In 1995 the Board entered into a contract with the Kentucky Physicians Health Foundation for these services. The purpose of the program is to promote the early identification, intervention, treatment, and rehabilitation of physicians who may be impaired by reason of illness, alcohol, or drug abuse, or as a result of any physical or mental condition. This program attempts to rehabilitate physicians and return them to the practice of medicine without having to take disciplinary action against their medical license. Prior to this time the Board worked closely with the KMA Impaired Physicians Committee.

Over the years the Board staff has gradually increased. Today 16 full time employees are

employed by the Board. The Board also retains the services of over 90 physicians who serve as Board consultants. Because of the growth of the Board's personnel, its headquarters office has had to relocate two times because of the need for additional office space.

At the present time the following individuals serve on the Board:

Royce E. Dawson, MD, President	Owensboro
Danny M. Clark, MD, Vice President	Somerset
Preston P. Nunnelley, MD, Secretary	Lexington
C. William Briscoe, MD	Corbin
Suvas G. Desai, MD	Richmond
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Virginia T. Keeney, MD	Louisville
Donald R. Kmetz, MD	Louisville
Rice C. Leach, MD	Frankfort
Ms Dorothy L. Newberry	Frankfort
Donald J. Swikert, MD	Florence
Emery A. Wilson, MD	Lexington

This is a brief summary of some of the many changes that have taken place over the past 25 years. Many challenges have been met and notable progress has been made over the years. The Board will continue to vigorously confront the issues that face it and strive to be more effective and efficient in order to carry out its statutory responsibilities.

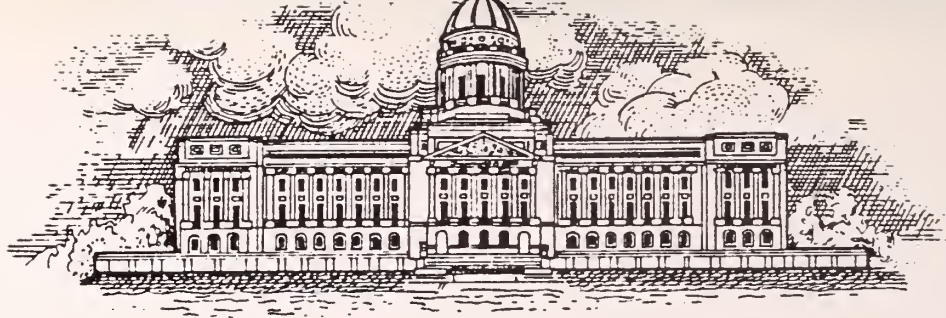
ADDENDUM

Much of the success of the Kentucky Board of Medical Licensure during the past 25 years can be attributed to C. William Schmidt. Mr Schmidt started with the Kentucky Board of Medical Licensure at its creation in 1972. The responsibilities of licensure prior to that time were handled by the Kentucky Department of Health. Mr Schmidt has been with the Board of Licensure since its beginning and is responsible for many of the changes that have been made.

Mr Schmidt has been the stabilizing influence that has allowed the Board to be one of the better boards of Medical Licensure in the United States.

We owe Mr Schmidt a great amount of gratitude for all of his dedication to the purpose of the Board.

— Royce E. Dawson, MD
President, KBML



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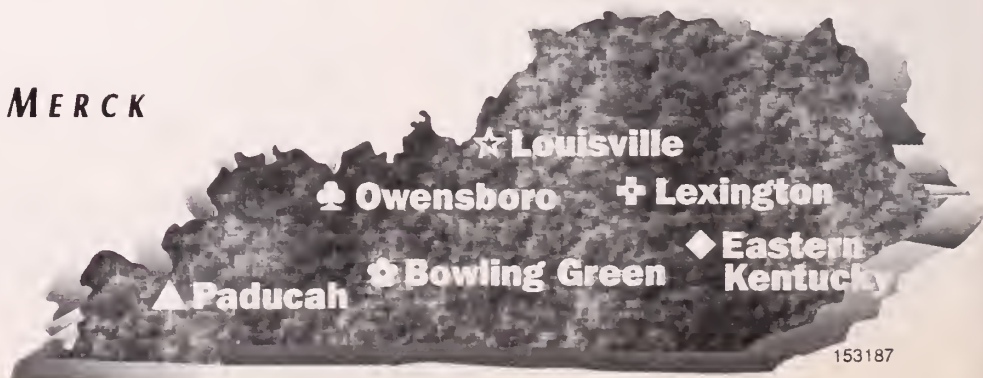


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Computer Requirements for Medical School Students – Implications for Admissions

Carol L. Elam, EdD; Robert F. Rubeck, PhD; Amy V. Blue, PhD; Giulia Bonaminio, PhD;
Lois Margaret Nora, MD, JD

Computers are increasingly being used in clinical practice settings. Aware of the need to educate students regarding computer applications in medicine, the University of Kentucky College of Medicine is in the midst of developing a computer curriculum. To that end, many courses and clerkships have devised software packages for transmittal of course information and for evaluation of student performance. This paper outlines requisite computer skills that applicants applying to medical school should possess, broadly reviews how those computer skills will be used in medical school, and suggests means for attaining computer competency prior to making application to medical school.

With the rapid expansion of the Internet, medical journals on line, and patient record files being converted to data stored on computers, physicians are faced with a growing reliance on computers for their clinical practice, office management, and continuing education. The need for physician training in the use of computers has long been suggested by national leaders in medical education including the panels filing both the General Professional Education of the Physician report (GPEP) in 1984¹ and the Assessing Change in Medical Education—The Road to Implementation report (ACME-TRI) in 1992.² The time to incorporate computer training in the professional education of medical students has come. This paper reviews how computers are being used in medical schools, outlines requisite computer skills that applicants applying to the University of Kentucky College of Medicine should possess, and suggests ways to gain computer skills prior to medical school matriculation.

Recognizing trends in the growth of computer applications in clinical settings as well as changes in educational practices brought about by the explosion of medical informatics, many medical schools have incorporated the use of computers within their curricula.^{4,8,9} Applications of com-

puters in the core medical curriculum across the United States include devising web pages for particular courses or clerkships, digitizing slides, radiographs, and CT scans on CD-ROMS for course and clerkship study, and devising computer simulations of patient encounters for evaluation purposes.

At the University of Kentucky College of Medicine (UKCOM) basic computing skills are an integrated part of the medical education process. Necessary skills include operating a computer, using word processing software, using e-mail systems, searching the Internet, finding medical literature on Medline, and accessing clinical data bases. These computer skills are introduced and reinforced throughout the basic science and clinical curricula in a sequential fashion. For example, several basic science courses have digital lectures on computers and course specific software for students to acquire additional course content. Radiographic images for the Introduction to the Medical Profession course are available on the computer for students to review. Since the 1995-96 academic year, several courses have offered discussion groups on the computer. Using computers to augment course-related discourse, students e-mail content-based questions to faculty lecturers for which answers are then posted for the entire class. Beyond the use of computers to facilitate student learning, both the Office of Academic Affairs and course directors rely upon e-mail contacts with students to post announcements as well as administrative and course requirements.

With the addition of computing to the curriculum, student access to computers has become an issue in many medical schools. Because of space and cost limitations, few medical schools can provide adequate computer facilities for all students.^{5,10} As a result, an increasing number of institutions are considering and implementing student computer ownership requirements. At the University of Kentucky College of Medicine, student purchase of a computer was strongly rec-

From the University of Kentucky College of Medicine. Dr Elam is Assistant Dean for Admissions; Dr Rubeck is Assistant Dean for Educational Development, Research, and Academic Computing; Dr Blue is Assistant Professor, Department of Surgery, and Curriculum Consultant, Office of Academic Affairs; Dr Bonaminio is Director of Basic Science Training; and Dr Nora is Associate Dean for Academic Affairs.

Computer Requirements for Medical School Students

ommended in 1994. With classes entering since 1995, computer ownership is required. The current computer requirement allows students to purchase either a Macintosh or Windows-based platform. While students have the option of desktop or laptop models, there are stringent guidelines on memory, microprocessor, connectivity, CD-ROM, and printing capabilities.

The increased reliance on computers raises the need for incoming students to have computer skills. Many medical schools expect students to acquire some basic knowledge regarding the use of their own computers, though not all provide training.⁵ Recent research indicates that comfort levels of medical students with their computer

skills have improved over the past decade. Two studies in the 1980s reported that many students had no experience with computers prior to medical school and felt apprehensive about learning to use computers.^{3,11} The attained computer skills for medical students claiming computer literacy were actually at a minimum level. Subsequent studies have indicated that incoming medical students have greater computer skills than earlier graduates.^{6,7}

At the University of Kentucky, it is recognized that not all students are equally prepared in the use of computers. Given that students' primary charge in medical school is to master biomedical objectives, their extracurricular time available to gain computer literacy competencies is limited. As a result, the College provides basic computer proficiency training programs for our medical students. For example, during medical school orientation, general sessions include training in the use of the computer for word processing, handling graphics, sending and receiving e-mail, accessing medical literature bases and course material stored on the Internet, and interfacing with remote computer communications. These are skills that will be used by students throughout the curriculum. In addition, supplementary student computer workshops and individual help sessions are also available throughout the academic year.

The UKCOM admissions office is trying to attract more applicants who are computer capable. To that end, the College of Medicine admissions committee is contemplating to what extent attained computer literacy should be a consideration for admission to medical school. Prior to the 1996-97 admissions cycle, documentation of computer literacy skills was not part of the admissions record at the University of Kentucky College of Medicine. However, with the 1997 cycle, applicants have been asked to respond to the following question on the secondary application, "How would you describe your current computer skills? (Include your comfort with computers, current proficiency, and plans for growth.)" Information on the computer skills of individual applicants will not be considered during the 1997 cycle in committee deliberations on admissions decisions. However, to obtain a baseline on applicant computer abilities, admissions officers will retrospectively review the data collected on all applicants throughout the cycle to gain a composite view of the self-reported computer literacy skills of our applicant pool. In asking the computer literacy question on the secondary application, we hope

Table 1. Computer Skills Checklist

The following skills are used early in the medical curriculum and are therefore best to possess before entering medical school.

- I. Operating a Computer**
 - A. Setting up the computer; Connecting peripherals; Using a CD-ROM; Making adjustments to the monitor
 - B. Using Windows or Mac OS; Demonstrating mouse dexterity; Moving and dragging icons
 - C. Using files; saving, finding, backup and sharing across applications
 - D. Using directories; Creating, removing, copying
 - E. Assuring security; Backup, surge protection, anti-virus software
 - F. Communicating about computers; Use of terminology such as RAM, ROM, software, hardware, floppy; Use of terminology to describe a problem, seek consultation with computer experts.
 - G. Using computer resources; Reading manuals, locating text sources, using consultations, attending training sessions
- II. Word Processing**
 - A. Launching word processing software
 - B. Creating a document; Typing in text, formatting text, formatting a document
 - C. Moving/copying/editing text
 - D. Using spell check/and thesaurus
 - E. Saving/opening a document
 - F. Printing a document
- III. E-Mail**
 - A. Entering/editing/sending messages
 - B. Receiving/reading messages
 - C. Identifying/managing/saving E-mail addresses
 - D. Setting up E-mail packages with personal information, preferences, settings and options
- IV. Internet Browsers (ie Netscape)**
 - A. Launching/opening the browser
 - B. Visiting a Website, Internet location or URL
 - C. Using browser function like back, open URL, reload & stop
 - D. Bookmarking a site
 - E. Using search terms to locate web sites
- V. Literature Searching**
 - A. Determining available literature and locating bibliographic citations
 - B. Printing out search results from literature databases
 - C. Searching available literature databases
 - D. Searching library holdings
 - E. Using Medline to locate a bibliographical reference

to alert applicants (and premedical advisors) formally that computer skills are desirable and necessary for our incoming students. Once students enter medical school, a detailed assessment of computer literacy skills is collected. Computer skill levels of our students are tracked and monitored throughout the four-year curriculum.

What specific computer literacy skills should applicants to medical school possess? Such information is important to admissions committees who may be asked to evaluate the adequacy of such skills in the future. It is also important to medical school faculty who are devising computer applications for their courses and clerkships. Perhaps most significantly, such information should be shared with premedical advisors who can impact the curricula at undergraduate institutions and better advise potential applicants. Table 1 details a checklist of skills which serves as a preliminary outline of computer literacy abilities expected of incoming medical students. This checklist is formulated from a theoretically based collection of relevant skills. Using routinely collected information from our entering students on their current levels of computer skills, we can improve the specificity and accuracy of the checklist over time.

There is no single, prescribed means for students to gain proficiency in computer skills before entrance to medical school. While it is not necessary for premedical students to take extensive computer programming classes, it is advisable for them to take advantage of computer facilities on their undergraduate campuses. Students should seek experiences to help them learn how to use their computers and understand their operating systems. While formal computer science courses may be of help, management information systems courses and informal training workshops on computer applications may be more useful. Beyond course work, many alternative computer resources are available to expand one's knowledge of how computers can help with learning. Many students find readable books and periodicals on computer applications readily available in campus and community bookstores. Such materials may be more user friendly than some computer software manuals. Other students review computer catalogs or browse at computer stores to get a sense of the range of computer applications and resources that are available. Perhaps most important for students is to adopt an attitude of curiosity and exploration in learning new facets of computer usage.

With the arrival of the twenty-first century,

applications of information age technology are an integral part of our lives. In outlining requisite computer literacy skills, implementing a computer ownership requirement, devising a computer curriculum, and communicating our initiatives to the premedical community, the University of Kentucky College of Medicine seeks to prepare our students for their medical education and for the practice of medicine both in the present as well as into the next century.

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C. Kenneth Peters, MD

KMA President 1997-98

Visualize a gentleman who seemingly arises each morning vowing to be kind to everyone he meets during the day. One who is approachable, affectionate, and always available for his patients—whose demeanor evokes not-too-distant memories of the quintessential “family doc”—an affable, optimistic man with a warm grin and a soft spot in his heart. As you cling to that vision, do an about-face and include in that profile an acute, astute, and resolute man—a super bright, futuristic thinking, take-advantage-of-the-technology buff who embraces the lightning speed changes being wrought as we race toward the 21st Century. You then have a sketchy silhouette of the physician who has just donned the mantle of leadership of the Kentucky Medical Association—C. Kenneth Peters, MD.

But there is more, much more, to this gentleman. Patient’s advocate, politician, historian, church leader, risk taker, are but a few of the mantles he dons. However, he considers the opportunity to help others when they are most in need of help his greatest privilege. He places stringent rules on the term “physician” and considers it vital to *actually care about patients* and *not just treat them*.

KMA’s new leader gives thoughtful consideration to his comments. Comments that are simple, eloquent. Without adornment. “We have the honor and affirmation on a daily basis of being called ‘doctor’ by our patients and sometimes by our friends,” he says, “and this is certainly affirming and appropriately deserved. But to me the definition of a physician reaches far beyond the definition of a doctor. I perceive a doctor as a doctor of

science, one who has mastered the art of science. To me, a physician is one who has the scientific and academic training, but who has mastered the art of caring about people.”

The Presidency

KMA’s new leader possesses the ability to pull people together around a common vision that unites physicians about the options for the future of health care. From this vision, he feels, should come strategic planning. “I can think of no greater time than the end of this century and the beginning of the new millennium, to pause, take an inventory of where we’ve been, where we are, and what our future goals should be,” he says. “During my tenure, I hope to be part of a process of self-study or long-range study to identify what our membership feels has worked, what isn’t working, and to execute long-term planning.”

Where all of the options haven’t been explored, Dr Peters calls on leadership to ensure that KMA is looking ahead and providing leadership into the future, rather than protection of a past that can’t be revisited. “Effective and responsible leadership must be out front on the cutting edge of issues. The office of the president certainly can be, for want of a better term, a ‘bully pulpit.’ There are areas for being a good cheerleader, affirming good work of staff, and also reaching out to other disciplines we need to work with. I envision our role including taking on some risk—having our membership to stretch a little bit. In a changing environment, the status quo is not going to be enough,” he says.

Adapting to Change

There is a reluctance, even a resistance, on the part of many to embrace the explosion of new communication technology. Telemedicine, the Internet, and the World Wide Web are dramatically changing the way information is delivered to doctors and the way medicine is practiced. President Peters acknowledges that the computer is here to stay, that it is a valuable tool, and that KMA membership had better log on.

“Managed care is demanding more and better documentation and greater speed and efficiency. Many of us grew up in a healthcare system which traditionally was a ‘mom and pop shop.’ Statistically today, that is a very small minority and will increasingly become less. We’re going to see fewer and fewer solo practices. As the next century emerges, we’ll see more networking, more coalescence of practices working together, perhaps in the partnership without walls. Statistics document that managed care is going to continue its maturation. This dictates that we as an organization, as individuals, must use every available tool to determine how we can be a part of the decision process that protects the patient and ensures access to good quality health care.

“For any organization, there’s no substitute for keeping people informed,” he says. “In the past, we’ve informed our membership on a timely basis, but in the future this will require modern technology. I see the opportunity of the Internet being an explosive communication system for the next century. E-mail is becoming

prevalent among our membership. We will have the ability for more instant response to information—and in turn to respond more quickly. Taking advantage of this ability will facilitate deliberate, responsible decisions. In this high-tech environment, the only thing that's going to be consistent for sure is the ability to change.

"We must assist our members in realizing that the module has changed, but the goals have not. The strategy is going to be the same, the opportunities will be there, but they're going to have a different focus. We must mature our thinking process so we don't get caught up in the mire of playing 'ain't it awful what's happened to medicine.' It really is the greatest opportunity of time. As Charles Dickens said, 'It's the best of times and the worst of times.' It's what we make it to be," says this optimistic leader.

Innovation & Risk Taking

Dr Peters' reputation for being innovative, for adapting and capitalizing on changes in the medical marketplace, for turning negatives into positives, is well grounded. He is willing to take a risk.

"During the early 80s, my two colleagues and I did a little reflection. We were running one of those 'mom and pop shops' and for some three years, we stood still. We didn't grow, we didn't go backwards . . . just stayed in limbo. I constructed a questionnaire, not too scientific, and took the next 300 patients who came through the door and asked them to complete it anonymously. They addressed issues about hours—morning hours, evening hours, Saturday hours. They affirmed things they thought we did well and wrote in areas where they thought we could do better. That's always risky—and you have to be willing to take that risk. But out of that questionnaire came an entirely new focus. I convinced my colleagues that many of our patients had undergone a tremendous change in lifestyle, that there were many single

parents, and we needed to address evening hours. We started in 1985 as a trial, and I took the first nontraditional hours. After a year it was so successful that everyone joined in, and it's been in effect for 12 years. Access to health care in the evening and on Saturday is probably one of the most significant contributions we've made to the community. We responded to the marketplace."

Acknowledging that, like it or not, medicine does have a business side that cannot be neglected, he expounds on the issue. "If we want to be competitors and are concerned about other groups affecting the private practice of medicine, then we must identify what areas we need to address—and get in there and compete. We've always said we wanted to compete in the marketplace because we've been one of the last bastions of the free enterprise system. Now that the challenge is here, we must be willing to step up to bat."

Introduction to Organized Medicine

Ken Peters had an auspicious introduction to organized medicine. In recalling the occasion, he displayed a touch of egotistical pride—a rarity for this soft-spoken, humble man. "Medicine's history has shown that most physicians have had mentors in their life, and it's been traditional in medicine to pass it on to the next generation. And, hopefully, what we pass on will be better than what we received. That was certainly true for me. Within my first year of practice in Jeffersontown, a very able leader of medicine, for whatever reason, picked me up and said, 'You need to get involved. I want you to be on the Legislative Committee, and you're going to be my key man.' I didn't even know the terminology, but I knew the gentleman speaking . . . that was Dr Hoyt Gardner, who was my mentor throughout my career."

Indeed, Dr Gardner did not release the pupil he obviously recognized as

a quick study. In not too many years, Dr Peters was named to the KEMPAC Board, he thinks as the youngest member ever, and "one year later in 1970, I was named Chair, a position I held for two years—and I might add with some degree of success. This experience reinforced my feelings that maybe I did have something to offer leadership, and it has continued from that day forward." He injects an enlightening comment. "The legislative agenda has always been 'fun' for me, and I've been on the KMA Legislative Committee for at least 20 years."

Dr Peters will be serving as President during a tough Legislative Session, and it just might not be "fun," but he welcomes the challenge to contribute his political expertise. And he has confidence that the groundwork laid by KMA's outstanding lobbyists has paved the way. "The perennial issue of healthcare reform is still on the minds of our constituents, and I think the majority of the legislative body, despite some of the leaders' denials. Our work is cut out for us, whether we tackle this issue in a special session this fall, or revisit it in the regular session. While we try to correct some of the inequities in access and other issues, we don't want to give up any ground that we have gained." He continued, "One of the major focuses and strategies for our lobbyists in Frankfort is to get a patient protection bill passed this year. Hopefully, we'll get broad support. It will be a great contribution if we can achieve this."

Membership

Dr Peters is quick to point out the importance of *all* KMA members. "The key to one of my commitments for this year is inclusiveness—involving more young physicians, more women physicians. If we don't get them involved early, their mission will be short served, and we all will be the lesser as a result.

"We started a new journey on August 28th when the Nominating

PRESIDENT'S LUNCHEON



Dr Peters' family joined him for this very special day. LtoR—Son Dr Chris Peters, wife Rhoda, daughters Anne and Elaine, and Elaine's husband, David Waxman.

Committee process began. At the August Board Meeting we asked and challenged every member of the present Board to go back to his or her district and talk with individual physicians, with particular emphasis on women and young physicians who have not been involved in the process, and ask them to commit to serving next year on a committee, hopefully in an area of their interest. We're going to use all those folks, and we're going to bring in some new talent. If you really want to change your membership, you go to the focus groups in the areas who are not now serving with the same intensity.

"No organization, whether it be for-profit or not-for-profit can really be effective in managing its resources or meeting its mission without effective leadership. Some folks are born to be followers and some to be leaders . . . and you hope that you don't get the wrong people in the wrong slot, because both are miserable if you do."

Personal

The son of a Methodist minister, Dr Peters' family moved every few years, as is the church's tradition. He was born in Owensboro, went to high school in Marion, which is near Paducah in Crittenden County, and

then returned to Owensboro to attend Kentucky Wesleyan College. While in high school he worked for a drug store, and the two pharmacists became his mentors. He left for college thinking he would become a pharmacist. However, the summer following his freshman year, he needed a job. Unbeknownst to him, that job was a major fork in the road to his future.

Dr Peters explains, "My father's boss was on the Board of the Henderson Community Hospital (then Methodist Hospital), and I became an orderly . . . I had never been in a hospital but once in my life, and then as a visitor. I must have proven the ability to adapt quickly, because I was adopted somewhat by the Henderson medical staff and subsequently applied to medical school at the end of three years. A few students did that then, so I skipped the senior year of college. Following medical school and a rotating internship at the Old Saint Joseph Hospital, I volunteered for the US Navy and spent two years as a medical officer. This was during the Cuban crisis, so we got a taste of what the military is really like."

Dr Peters assumed that the decision on his practice location would be made by others, but a technicality intervened. He related,

"I was the recipient of a Simpson's Scholarship from Dr Simpson of Greenville. This was a full tuition scholarship for a student willing to go back to their home county to practice. That seemed to be harmless, except no one had dealt with the fact that by the time I was ready to establish a practice, I had ten different choices where my parents had lived in my lifetime. They couldn't figure out which slot I was in, where they were going to send me to meet the criteria. Well, I considered some of those options and decided they weren't where I wanted to live. I paid the scholarship money back and came to Jeffersontown, which was my choice. I've been there since."

Family & Leisure Time

Ken Peters married his college sweetheart, Rhoda, at the end of his first year of medical school. "Dr Don Stephens, KMA's current President-Elect, was in our wedding," he reminisced, as an aside. They have three grown children, and this doting grandfather was not too busy or involved to note that one of their two granddaughters would be having a birthday in a couple of days.

He speaks glowingly of their children. "The eldest, Elaine, earned a

masters degree in health policy at the University of Chicago and is presently working on her PhD at the University. Her husband is an attorney specializing in malpractice defense—so he's on our side. That was a disclaimer we made before they married!

"Daughter Anne is the artist of the family. She earned a master's degree in art therapy from the University of Louisville and now lives in Bloomington, Indiana, where she is a counselor for freshman girls at Indiana University. We have a unique time during basketball season with our loyalties being divided.

"Our youngest is Christopher. He graduated from medical school in 1994 and recently began his fourth year residency. He is doing quite well as a fellow in the department of psychiatry specializing in adolescent and child psychiatry."

When he's not carving out ideas for attaining optimal family care, Dr Peters is "attending meetings." "I spend my free time going to meetings," he says. "That is, if you want to know what I've done with consistency. Hopefully that's some contribution," he adds tongue-in-cheek.

"I'm not a golfer—it never interested me and I just never designated that kind of time," he says. "I do enjoy fishing when time permits. I minored in political science in college and have a great appreciation for American history. Throughout the years, I've been a regular reader of political history . . . and probably could give you a fairly erudite critique of all the presidents since Franklin D. Roosevelt."

Dr and Mrs Peters have paid little heed to the reciprocity clause in The Golden Rule. They simply "do unto others." He relates, "I guess you could say I'm a regular volunteer. I've never forgotten the statement AMA President Dr James Davis made in his inaugural address that physicians receive so much from their patients and the community they serve, that we have a moral and ethical obligation to give

back as much as we can. As the newly elected President of the Jefferson County Medical Society, his message really inspired me anew. Rhoda and I had adopted that philosophy because the church has been very much a part of our lives. Both of our fathers were Methodist ministers, which is unique, and we've been actively involved in the United Methodist Church at its highest level. I served on the college board and presently serve on the board of trustees of the Wesleyan Manor Retirement Home. I'm Vice President of the Healing Place, a project I've been involved in since its inception."

This busy physician somehow forgot to mention a few other little contributions to his community—such as serving for 25 years as team physician for Jeffersontown High School and being a Past President of the Jeffersontown Rotary Club!

While humble about his own accomplishments and contributions, he is lavish with praise as he recalls many of his wife's accomplishments—aside from devoting her full time to their children when they were small. "Rhoda was the first educational television teacher in Jefferson County, on a program sponsored by the Ford Foundation; she is a master in the art of communication with special training; directed community theatre in Jeffersontown when the children were small; chaired the committee for the Jeffersontown Library—it took four years and four different county judges, but we have a major satellite library in Jeffersontown because of her efforts; served with elegance as one of the youngest women ever elected President of the United Methodist Women of Louisville Conference; was Associate Director of Leadership Development for the Louisville Annual Conference; Director of Programs for St. Paul Church on Douglass Boulevard, our second largest church, for ten years; appointed by the Bishop of the church as Council Director for the entire program conference; currently serves as Director of

Discipleship Team Formation for the entire United Methodist Church."

He continued, "As Kentucky Wesleyan alumni, we attended the graduation exercise at their invitation on May 12th of this year. Rhoda was awarded the highest honor that comes to alumni—an honorary Doctor of Divinity Degree. So it's now Dr Rhoda Peters, but she insists she will not treat your sore throat!"

Presidential Achievements

Dr Peters holds no aspirations of grandeur for his presidential year. He recognizes that many KMA programs and goals are time dependent and require a continuous process over several years. But he is in a race with time on one major issue. "The old saying is, 'Never put all your eggs in one basket,' but to bring closure to the possibility of a statewide PPO and to get it off the ground is a predominant concern. Time is slipping away and the opportunity is short to bring this to closure." If this is accomplished, he will view his presidential year a success.

Assessing the year philosophically, Dr Peters quoted one of his mother's favorites. "Whatever you do, Ken, if it's worth doing at all, do it well." She would be pleased by his comment. "So I would like to think that 'I did it well,' and we will be a little better off at the end of the year than when we began."

Ken Peters will "do it well," because he is happy to be a key participant in bringing people together so that, jointly, beneficial decisions and outcomes will prevail for all. His legacy as KMA President is credulous . . . "To be remembered as someone who was willing to be involved, who was really proactive in expanding the level of participation—involving more people in the decision making, giving more people ownership in our organization . . . and that I wasn't afraid to take a risk."

—Sue Tharp
Managing Editor

The French Paradox, Confounded

T*he details of these studies are unpublished elsewhere but I am able to sneak a preview of the findings here.*

Notoriously happy sinners, the French eat well, drink well, sex well, but escape the price the rest of us pay of waking up dead in our prime. Now they have demonstrated the ultimate prize in health care prophylaxis: a taste-good, feel-good, nostrum that protects their carefree bodies from premature expiration — red wine.

Who could believe it? Our, and their, statisticians set about to discount the positive effect of red wine on atherosclerosis but simply affirmed that red wine is more effective than white wine which is more effective than bourbon which is more effective than water.

In disbelief I undertook two anecdotal series performed on site with only two motives: to illuminate the facts and to deduct the trips. The details of these studies are unpublished elsewhere but I am able to sneak a preview of the findings here.

For two weeks each in May 1996, and May 1997, the person on the street was randomly and continuously observed from an obscure but not hidden vantage point in one of two sites: a sidewalk cafe and a beach cafe.

In the first study 1,313 subjects were assessed, eye-ball wise. Of these, 51 subjects were obese. Using the same protocol, the second series of 1,769 serial observations uncovered 31 heavy-set individuals. The simple percentages of overweight victims were 3.8 and 1.7. Subsets from each series were observed in greater detail. They would eat such menus as a large bucket of mussels and an obscene pile of fries, with wine or, giving no thought to their own health, water. The bucket of mussels slowly disappears. The pile of fries is half consumed. When the researcher orders couscous and potatoes, the waiter declines to bring the potatoes because it duplicates the dietary category of couscous. However, he will permit me to have an artichoke and drawn butter.

Is it possible that an unrestricted but prudent diet might be as important as a glass of wine to protect the aging vascular system?

A. Evan Overstreet, MD
Editor

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*Lou's gradual hearing
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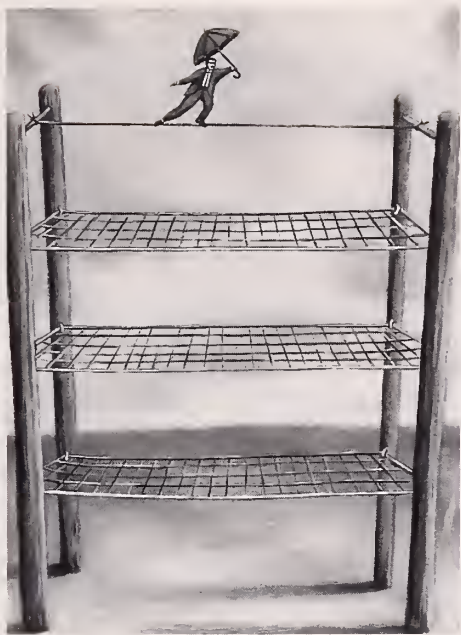
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Aroona Dave

SAVE speaks to all of us

I am thrilled that upon the request, our Governor Paul Patton has signed the proclamation that is featured in this article. Angie DeWeese, Legislation Vice President, has worked hard to make it possible. It was an honor to meet Mrs Patton, of whom I had heard so much.

Johnnie Amonette, AMA Alliance

President and spokesperson for SAVE, sends the message.

1997-98 project is to reach out at least to one child with the message to break the cycle of violence and I am confident TOGETHER WE CAN DO IT.

Aroona Dave
KMAA President



Johnnie Amonette

We're all victims of violence, in more ways than you might realize. Those of us who are abused by a spouse or attacked by a stranger are victims, to be sure; but so are those of us who cannot find decent media programming for our children. And so are those who cannot walk alone down a street. And so are those of us driven to fear and mistrust of our fellow human beings. And so are those of us—all of us—who bear the financial costs of violence, the enormous burden it places on the health care system, on the medical community, on physicians, and on physicians' spouses.

This is why the AMA Alliance's nationwide SAVE Program to Stop America's Violence Everywhere is so vitally important.

Whether family violence, gun violence, child and elder abuse, or media violence, the SAVE program seeks to understand its causes, attack its roots, and aid its victims. SAVE encompasses more than 700 Alliance programs at the state and county levels—everything from fund-raising efforts and legislative initiatives to public education campaigns and one-to-one assistance.

The cornerstone of our year-round SAVE program is "SAVE Today"—and our third annual "SAVE Today" will be celebrated across the country on Wednesday, October 8, 1997, with in-school pledges of "no violence" by students of all ages, educational and awareness programs for parents and physicians, events to collect needed items for abuse shelters, remembrances to honor victims of violence, and hundreds of public "SAVE Today" proclamations by national, state, and local officials.

So please join the members of the Kentucky Medical Association Alliance in celebrating "SAVE Today" and heralding the medical community's efforts to end violence. It takes one small step from each of us to affect the lives of many. If we help one person out of an abusive situation or break one child away from the cycle of violence in our communities, on our television sets, and in our homes, together we can stop America's violence everywhere.

Johnnie Amonette
AMAA President

Proclamation

by

Paul E. Patton
Governor

of the

Commonwealth of Kentucky



To All To Whom These Presents Shall Come:

- WHEREAS, Violence is among the leading causes of death in America, and has replaced disease as the number one killer of children; and
- WHEREAS, Domestic violence has devastating effects on a woman's physical and emotional well-being, and her ability to care for her children; and
- WHEREAS, Violence comes in many forms, sexual violence; gang and peer-related violence committed by youth of all ages; family violence; street violence; and violence in the media; and
- WHEREAS, Billions of dollars per year are attributable to preventable violence-related deaths and injuries and add a tremendous burden to America's health care system; and
- WHEREAS, The first step toward unraveling the many layers of our nation's violence problem can begin with awareness; and
- WHEREAS, Awareness and prevention are the heart of the SAVE Program and of its cornerstone event, SAVE Today, during which physicians' spouses across the country will join efforts to Stop America's Violence Everywhere; and
- WHEREAS, Members of the Kentucky Medical Association Alliance will lead an effort to urge local citizens to search for ways we can all help SAVE Today for Tomorrow.

NOW, THEREFORE, I, PAUL E. PATTON, Governor of the Commonwealth of Kentucky, do hereby proclaim October 8, 1997 as

SAVE TODAY

in Kentucky.



DONE AT THE CAPITOL, in the City of Frankfort, this the 27th day of August, in the year of Our Lord One Thousand Nine Hundred Ninety-seven and in the 206TH year of the Commonwealth.

PAUL E. PATTON
GOVERNOR

John Y. Brown III
Secretary of State



SAVE
Stop America's
Violence Everywhere
American Medical
Association Alliance, Inc.

MEMBERSHIP
IS
EVERYONE'S
RESPONSIBILITY

I PROMISE
TO GET ONE NEW
& RETAIN ONE
MEMBER
KENTUCKY MEDICAL
ASSOCIATION
ALLIANCE

Report of Reference Committee A AMA Annual Meeting

At the AMA Annual Meeting in June, Reference Committee A received 8 reports from the Board of Trustees and Council on Medical Service and 25 resolutions for consideration. As usual, these issues ranged from Medicare changes for reimbursement for medical services to regulation of insurance. These reports and resolutions were considered by the committee in its final report, which was adopted by the House of Delegates. In general, the reports and resolutions all represented suggestions for solutions to the problems faced by Kentucky physicians.

It is noteworthy to point out and outline some of the more important resolutions and Board recommendations, and I shall attempt to do that in a brief fashion. Report 5 of the Board of Trustees, concerning "Medicare Conversion Factor Update," recommended pursuing legislation to implement a Medicare conversion factor update system similar to the Physician Payment Review Committee's sustainable growth rate (SGR) system as a positive alternative to the current Medicare Volume Performance standards. Several resolutions address the government shifting of funds between Medicare Parts A and B for reimbursement of home health services. In other words, the costs of home health services and many other medical programs have been shifted into the physicians' service component, Part B. Resolutions were adopted requiring closer monitoring of post-hospital custodial care, calling for home health care reform.

Resolution 111, calling for PSA screening tests to be covered under Medicare, was referred to the Board of Trustees.

The Council on Medical Service Report 7 was a long and controversial report outlining recommendations to improve access for the underinsured and uninsured. This report precipitated a lengthy and heated debate over many of its recommendations and ultimately was significantly amended prior to its passage.

Resolution 113, which addressed Kiddie Care, was incorporated and considered as part of that report.

I have briefly tried to outline some of the more controversial discussions and policies which will have the greatest effect on Kentucky physicians.

Again, it was a privilege to monitor this important reference committee as your Alternate Delegate to the AMA.

Bob M. DeWeese, MD
AMA Alternate Delegate

PEOPLE

Thomas James, III, MD, Louisville, has been elected to Fellowship in The American College of Physician Executives.

The Kentucky Division of the American Cancer Society has presented the St. George Medal to **John S. Spratt, MD**, in recognition of his outstanding contributions to the control of cancer. Dr Spratt served as division president in 1995-96 and was one of the first ACS professors of clinical oncology in the state. He held that position at the University of Louisville from 1976 until 1981.

Leah Dickstein, MD, recently celebrated her 25th Anniversary in the Psychiatry Department of the University of Louisville School of Medicine.

Tracey Corey Handy, MD, Louisville, has been named Kentucky's Chief Medical Examiner. Dr Corey Handy, a forensic pathologist, will replace **Dr George R. Nichols II**, who is retiring after 20 years as the Commonwealth's chief medical examiner. Dr Corey Handy has worked with Dr Nichols since 1991 as Assistant Medical Examiner.

Lelan K. Woodmansee, CAE, Jefferson County Medical Society's Executive Director, was listed this year in the *International Who's Who of Professionals*.

UPDATES

Family & Community Medicine 25th Anniversary

The University of Louisville School of Medicine Department of Family and Community Medicine celebrated its

25th Anniversary recently. Since its creation in 1972, the program has graduated a total of 138 residents. All of the chairmen of the department since its founding were on hand for the celebration. They are: **Richard D. Clover, MD**, the present chair; **Kenneth E. Holtzapple, MD**, 1981-1995; **John C. Wright, MD**, 1978-1981; and **William P. VonderHaar, MD**, 1972-1978.

Physician Practice Mergers

According to Irving Levin Associates, the number of mergers and acquisitions involving physician groups reached 242 in 1996, a record 92% increase from the 126 deals that took place in 1995. Over 19,950 physician practices were affected by deals, an increase of 122% from 1995. The record activity reflects the boom in the physician practice management sector, which outpaced the hospital sector in number of deals.

Children May Sue for the Wrongful Death of a Parent

The Kentucky Supreme Court has ruled that a child may sue for "loss of consortium" in the death of a parent. The 4-3 ruling means children may now recover damages for the wrongful death of a parent. Spouses may already recover such damages for the death of another spouse and a parent may recover damages for the death of a child. This latest ruling from the Supreme Court comes from a case involving a woman's death while giving birth at Central Baptist Hospital in Lexington.

FDA Clearance

TAP Holdings Inc has announced clearance from the US Food and Drug Administration to market Lupron Depot® 4 Month 30 mg (leuprolide acetate for depot suspension) for

Dr Weiler Named Citizen Doctor of the Year



Sanford L. Weiler, MD, Harlan, has received the Citizen Doctor of the Year Award, the Kentucky Academy of Family Physicians' most prestigious honor.

Dr Weiler served as KAFP President in 1995-96 and as president of the Harlan County Medical Society for two terms. He is a clinical assistant professor in the Department of Family Practice, University of Kentucky College of Medicine.

He has been in a multispecialty group practice in the Daniel Boone Clinic since 1982 where he has served as secretary and board member and will serve as vice chair of the KAFP Foundation in 1997-98.

Dr Weiler is extensively involved in community and philanthropic efforts in the Harlan area.

KMA congratulates Dr Weiler on this well-deserved honor.

palliative treatment of advanced prostate cancer. TAP's report states that because of the drug's long-acting formulation, patients receive only one injection of Lupron Depot-4 Month 30 mg every 16 weeks to treat their condition.

VIVUS, Inc has announced the US commercial launch of ACTIS® (Venous Flow Controller), a new treatment for erectile dysfunction, more commonly known as impotence. ACTIS is a fully adjustable penile band which is placed around the base of the penis to impede blood flow out of the penis. ACTIS was cleared by the US Food and Drug Administration in December of 1996.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyle

John Lowell Carrick MD — P
2053 Cardinal Dr, Danville 40422
1968, U of Texas, Galveston

Christian

Venkateswara R Velaga MD — C

1910 S Virginia St, Hopkinsville 42240
1979, Guntur, India

Davies

Mukesh Desai MD — U
1100 Walnut St, Owensboro 42301
1980, Seth, India

Mukesh Gupta MD — C
815 E Parrish Ave Ste 410, Owensboro
42303-3222

1982, Maulana Azad, India
Thomas C Logan MD — OTO
2211 Mayfair Ave Ste 405, Owensboro
42301

1992, U of North Carolina
Alan P Mullins MD — S
1407 Griffith Ave, Owensboro
42301-3502
1990, U of Louisville

Floyd

Scott C Mirani MD — PMR
121 Bowles Park Apt D3, Pikeville
41501
1989, U of the East, Philippines

Hardin

Bankole O Botu MD — IM
3822 Deer Haven Dr, Elizabethtown
42701
1987, College of Health Sciences, Nigeria

Henderson

Robert L Fawcett MD — EM
2401 McDowell Rd, Evansville IN 47712
1981, Indiana U

Hopkins

Dale E Lehmann MD — END
200 Clinic Dr, Madisonville 42431
1965, St. Louis U

Jefferson

Michael Bradley Calobrace MD — S
2206 Grinstead Dr, Louisville 40204
1989, Indiana U

Talal Faris MD — END
2405 Glen Eagle Dr, Louisville 40222
1987, Damascus, Syria

Barbara M Freeman MD — GP
9200 Shelbyville Rd Ste 700, Louisville
40222

1974, U of Louisville
Richard I Haddy MD — FP
3138 Sunfield Cir, Louisville 40241-6526

1976, Michigan State, E Lansing
Sarita Nair MD — IM
7217 Wood Briar Rd, Louisville
40241-6237

1989, Bangalore, India
Suresh Nair MD — IM
7217 Wood Briar Rd, Louisville
40241-6237

1989, Bangalore, India
Tariq Sayyad MD — IM
931 Mallard Creek Road, Louisville
40207-5494

1991, Aga Khan U, Pakistan
Michael R Swenson MD — N
495 Lightfoot Rd, Louisville 40207-1865
1976, U of Minnesota

Rowan

Harold L Halfhill II MD — R
222 Medical Circle Dr, Morehead 40351
1991, U of Kentucky

Washington

Asif Mahmood MD — IM
304 Mayes Ave, Springfield 40069
1987, U of Sind, Pakistan

Whitley

Eddie S Perkins DO — OBG
2 Trillium Way Ste 200, Corbin 40701
1992, U of Health Sciences, Missouri
Truman Perry MD — FP
121 Bishop St, Corbin 40701
1990, U of Kentucky

John M. Draus, MD
Louisville
1943-1997

John M. Draus, MD, a general surgeon, died July 22, 1997. Dr Draus graduated from Loyola University, Stritch School of Medicine, in 1968 and was an associated member of KMA.



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DEATHS

John W. Grover, MD
Ft. Thomas
1923-1997

John W. Grover, MD, a retired family practitioner, died July 14, 1997. A 1947 graduate of Case Western Reserve University School of Medicine, Dr Grover was a life member of KMA.

August Board of Trustees Meeting

The KMA Board of Trustees met in regular session on August 6-7, 1997, at KMA Headquarters in Louisville. The Board members heard routine reports from the President; Secretary-Treasurer; Alliance President; Secretary, KMA Physicians Plan, Inc; Senior Delegate to the AMA; Kentucky Medical Insurance Company; Kentucky Board of Medical Licensure; KEMPAC Board of Directors; and the Commissioner, Bureau for Health Services.

Additional reports were given on activities of the Committees on National and State Legislative Activities, Committee on Medical Insurance and Prepayment Plans, Committee on Service and Participation, and the Committee to Investigate Changing Trends in Medicine.

The Board voted to continue the Legal Trust Fund voluntary assessment at \$25. The KEMPAC Board of Directors and *Journal* Editors were appointed, and a Judicial Council nominee was approved. An amendment to the Constitution to provide delegate slots for the UK and UL medical school deans was approved to present to the 1997 House of Delegates.

Reports were given on the Medicaid Regional Partnerships, membership, and the Annual Meeting; and action was taken on 40 committee reports.

The next meeting of the Board was scheduled for Sunday, September 14, 1997, during the KMA Annual Meeting.

TOP: President William H. Mitchell, MD, and Board Chair Harry W. Carlross, MD. **CENTER, LtoR:** 5th District Trustee Daniel W. Varga, MD, and 9th District Trustee J. Gregory Cooper, MD. **BOTTOM:** President-Elect C. Kenneth Peters, MD; Secretary-Treasurer William P. VonderHaar, MD; Immediate Past President Danny M. Clark, MD. Dr. Walter I. Hume is pictured in the background.



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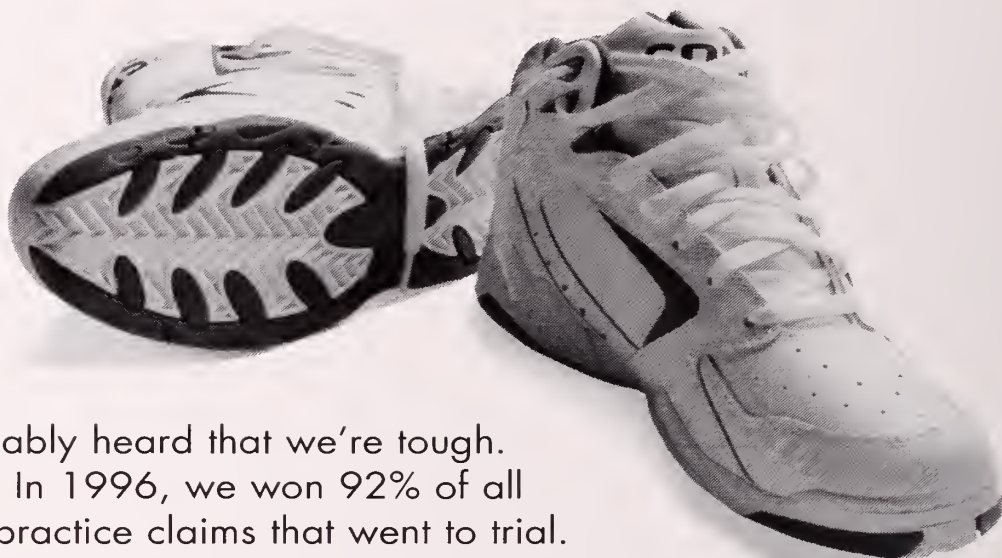
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NOVEMBER 1997

COVER STORY	Results of the Kentucky High School Football Knee Injury Survey <i>Brian D. Stocker; John A. Nyland EdD, PT,ATC; David N. M. Caborn, MD; Roy Sternes, MS, PA, ATC; J. Michael Ray, MD</i>	458
SCIENTIFIC	Polymphocytic Leukemia: Diagnosis and Treatment <i>Cem Akin, MD, PhD; Patricia Hansen, MD; Anthony Janckila, PhD</i>	465
SPECIAL ARTICLES	Interprofessional Code — Kentucky Medical Association and Kentucky Bar Association	469
MEDICO-LEGAL	Audits, Investigations, and Serious Trouble <i>Martha J. Hasselbacher; Marc S. Murphy</i>	480
EDITORIAL	The Coming Plague <i>Jaroslav P. Stulc, MD</i>	475
ASSOCIATION	<i>Monitoring Medicine</i> Actions of Reference Committee E — AMA Annual Meeting Committee to Investigate Changing Trends in Medicine Report on Fraud and Abuse Laws Diane M. Maxey Elevated to KMA Executive Staff Kentucky State-Wide CATO Society Meeting Physician Recognition Awards News	455 484 489 483 488 486 491
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page	453 494 479

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Unsung Heroes

The 147th session of the Kentucky Medical Association adjourned at 10:20 pm ET on September 17, 1997. Some of us stayed over for continuing educational opportunities, but most of us—members, spouses and guests returned to our individual towns and hamlets to pick up our calls and open all of that enormous mail collection that had accumulated during our brief absence. We were returning to our patients to care for their medical needs, which is what we do best. In the meantime, our KMA staff consisting of 21 highly dedicated and competent people under the capable leadership of our Executive Vice President, Bill Applegate, began packing up all the equipment, organizing the paper trail which had kept our meeting moving properly, and preparing for the follow-up necessary to complete the work of the House of Delegates.

Since I have been involved for the past seven years as one of your Speakers, I thought I had a good insight into staff time and commitment, and all of the triage which they do for our members and the KMA Alliance and guests during the annual meeting. This year, however, as I prepared for the President's Luncheon, I spent much more time in the staff room with various KMA staff and gained a greater insight than ever before.

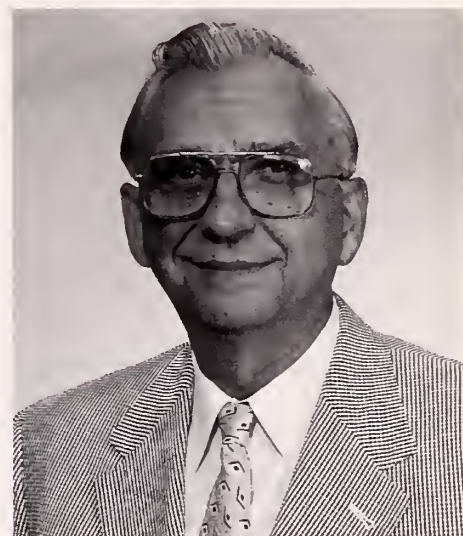
There is never a dull moment in the KMA staff room. In some quarters you might accurately describe it as the "war room," that insures an effectively run meeting. There is a continuous flow of humanity in and out of the staff room; staff answering phone calls; staff with walkie-talkies responding to a crisis in the Exhibit hall; staff answering

another of a hundred questions about the location of a committee, an event or a proposal. The stream of members, retired members, spouses and visitors seeking directions or a copy of their Reference Committee report was continuous. At no time during these encounters did I see any staff person lose his/her cool. In fact, they responded promptly with a smile no matter how late in the day or how tired their feet! In the middle of one of the busiest times on Tuesday afternoon, the staff responded immediately to a call for help when one of our retired physicians became acutely ill in the lobby. They called for physician help, called EMS and reassured the family. I was impressed that in the midst of meeting pressures they definitely kept their priorities straight. On the other hand, I saw even executive level staff assisting out of town guests and latecomers in quickly finding seating in a capacity crowd at the President's luncheon. No job was too trivial!

It is so easy in our high tech medical world to lose sight of the people who create the environment and support system that allows us to serve our association efficiently and with dignity. Friends, these staff persons are truly the unsung heroes of the KMA. The organizational chart on the following page will provide names for the people you always wanted to know about and perhaps were afraid to ask about.

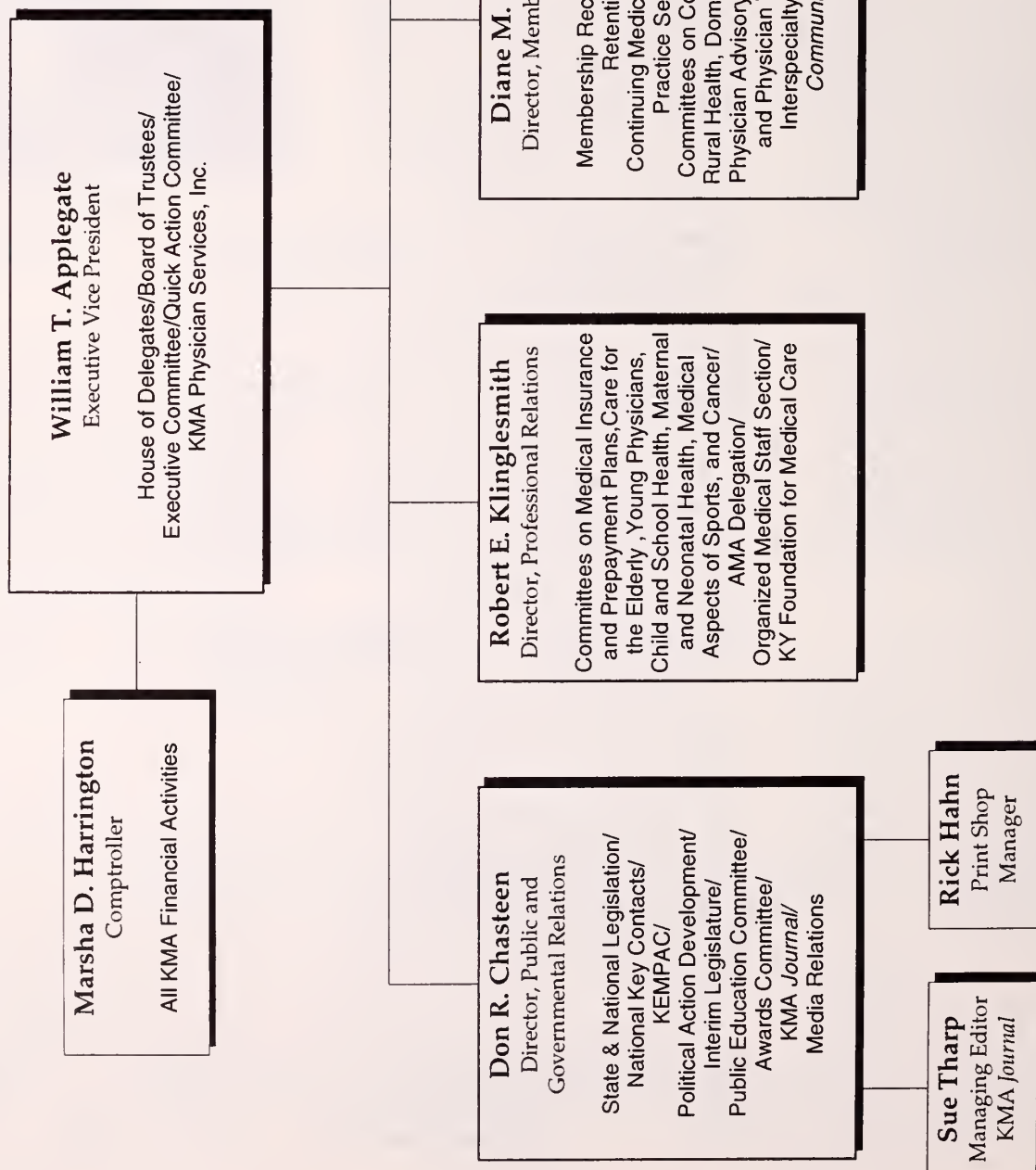
On behalf of all of us, I express our great appreciation to these who make up our KMA staff, our "unsung heroes."

C. Kenneth Peters, MD
KMA President



C. Kenneth Peters, MD

"It is so easy in our high tech medical world to lose sight of the people who create the environment and support system that allows us to serve our association efficiently and with dignity."



MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

KMA 1998 LEGISLATIVE GOALS

The 1998 Kentucky General Assembly convenes January 6, 1998, for 60 legislative days, and is expected to adjourn on or about April 15, 1998. Typically, over 1500 legislative proposals are introduced, of which 200 will be health or medically related. A legislative handbook will be mailed with the January issue of the *Journal of the Kentucky Medical Association*. The handbook includes pictures and biographical information on all legislators, how to call, write, or contact individual members, and KMA Legislative priorities.

The KMA House of Delegates has established the following legislative priorities:

PATIENT PROTECTION

The KMA supports legislation to monitor managed care procedures and policies, preservation of quality care within the plans, guaranteed access to necessary medical care, and assurance of fairness to patients and providers. In order to accomplish these objectives, the KMA recommends the following:

- Terms, conditions, appeals mechanisms, prior authorization procedures, restriction on access to care, and other patient information must be defined and placed in writing to insured individuals.
- Specific disclosure requirements are mandated including lists of providers by counties, specialty, and hospital affiliation. Disclosure of any financial incentives to providers, and other appropriate consumer information must be available to the insured.
- Patients' right to choose their primary physician and the right to access a specialist as a primary care provider when obviously indicated or medical conditions warranted must be available in all such managed care plans.
- Patients must be assured that a managed care plan has adequate staffing including sufficient numbers of primary care, specialists, and facilities.

- Patient and provider telephone access to the managed care plan must be available and reasonable waiting times for decisions on medical care assured. Retrospective denials of claims, when the managed care plan is not accessible by phone, should be sharply restricted.
- Emergency care should be defined, so that a prudent layperson can easily understand the terms and conditions of the contract. Emergency care must be available without authorization, and retrospective denial of emergency care should be sharply limited or restricted.
- Gag and inappropriate disparaging clauses should be prohibited.
- Managed care plans for deselection or termination of providers must be available to providers in writing. The procedures for terminating or deselecting a provider should include notification in writing, reason for termination or deselection, and a hearing held within 30 days if requested by the provider.
- Point of Service option should be available through all managed care plans. Point of Service permits the individual to access "out of plan" providers. Under the "point of service option" the insured agrees to pay additional premiums and/or established deductibles or co-pays.
- Managed care or insurance company employees or medical directors making medical decisions or countermanding treating physician decisions, should be fully accountable to the patient and their families for decisions which deny, delay, or impede access to medical care.

TORT REFORM

Defensive medicine, liability premiums, and costly legal action is a major driver of health costs. In a study of Kentucky's professional liability climate, statistics gathered by Kentucky's major professional liability company indicated that less than 38 cents of the dollar ended up in the injured patient's pocket. The remaining 62

The logo for the Kentucky Medical Association (KMA) is displayed in a stylized, bold, outlined font.

cents went to the system. Based on studies by the KMA, major liability insurance companies, and a special liability task force appointed by the Kentucky General Assembly, we recommend the following:

The KMA supports a Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards. Section 54 of the Kentucky Constitution states, *"The General Assembly shall have no power to limit the amount of injuries resulting in death, or for injuries to person or property."*

Amendment of Kentucky's Constitution requires affirmative votes of three fifths of members of the General Assembly and submission to the voters of Kentucky for ratification or rejection.

HEALTH AND SAFETY

- The KMA supports mandatory health education in grades K to 12.
- Allowable blood alcohol content (BAC) of Kentucky drivers should be reduced from 0.10 to 0.05.
- Periodic testing of vision should be required at time of driver's license renewal.
- Minors should be prohibited from riding in the rear of open trucks on Kentucky's roads or highways.
- Mandatory motorcycle helmet laws should be retained.
- Reasonable laws relating to water and boat safety and operation should be enacted.
- Bicycle riders should be required

to wear approved helmets when traveling on roadways or streets.

The KMA urges every County Medical Society to meet with their legislative delegation and discuss medicine's objectives prior to the convening of the Kentucky General Assembly. In addition, we urge individual physicians to discuss these same issues with their legislators by phone, and more effectively, through either personal contact or by letter.

The 1998 Session has the potential to be very divisive, especially along partisan political and philosophical lines. These same issues create divisiveness within the medical community. Amendments to these or other legislative proposals can immediately alter KMA's position. Issues of interest to physicians expected to arise include:

- Various abortion procedures, including access and requirements of providers.
- Definition of a physician office as it relates to abortion procedures.
- Physician office exclusion from Certificate of Needs (CON).
- Licensure for physicians practicing via "telemedicine."
- Expansion of the role of Health Departments and authorization to compete with private physician offices.
- Expansion of the roles of non physician practitioners.
- Prescriptive authority for Physician Assistants. (KMA supports)
- Alternative health and medical practice.
- Local control of tobacco sales and use. (KMA supports)

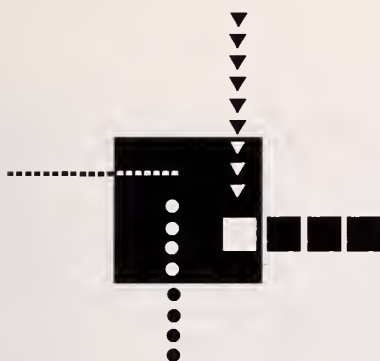
- Prescriptive fraud and abuse.
- Access to Physician data bank information by the public.
- Medicaid/Long Term Care/Child Health Care.
- Purchase of "non profit" health care facilities by "for profits."

During Sessions of the Kentucky General Assembly, KMA operates under the following policies and procedures adopted by the KMA House of Delegates:

- (1) All state legislative proposals are to be coordinated by and channeled through the Chair of the Committee on State Legislative Activities.
- (2) The composition, authority, and function of the Quick Action Committee are retained.
- (3) The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chair of the Committee on State Legislative Activities and the KMA Quick Action Committee.
- (4) KMA lobbyists in Frankfort during the Kentucky General Assembly are responsible only to immediate superiors and not to individual members of the Association. Any complaint relative to the state legislative program or its operation should be directed to the Committee on Legislative Chair and not to staff.

Wally O. Montgomery, MD
Chair, Committee on
State Legislative Activities

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

December 4-8, 1997
Wyndham Anatole Hotel
Dallas, Texas

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- Joint Commission's ORYX initiative
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- Fraud and abuse compliance
- Advocating your issues at home
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- Medical staff reengineering and bylaws
- Forming a physician organization
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In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- ▼ Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- ▼ Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- ▼ Attend practical education programs to improve your medical practice, earn **10.5** hours of CME credit** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1997 Interim AMA-OMSS Assembly Meeting on December 4-8, 1997, at the Wyndham Anatole Hotel in Dallas, Texas. To receive more information and registration materials, please call **800 621-8335** and ask for the **Department of Organized Medical Staff Services**.

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 10.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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Results of the Kentucky High School Football Knee Injury Survey

Brian D. Stocker; John A. Nyland, EdD, PT, ATC; David N. M. Caborn, MD;
Roy Sternes, MS, PA, ATC; J. Michael Ray, MD

The study attempted to: 1) determine knee injury and reinjury incidence of Kentucky high school football players; 2) relate results to initial care provider, treatment following initial physician exam, time lost from injury, injury type, player position, and team size; and 3) assess coaches opinions and practices about lateral prophylactic knee brace (LPKB) usage and effectiveness.

A post season, mail-in coaches' survey (50.2% return, 101/201) collected these data. Returned surveys represented 4690 players with average team size ($x \pm SD$) of 43 ± 13 . Two hundred fifty seven reported knee injuries yielded .055 knee injuries/player with .04 knee injuries/player being "new" and .015 knee injuries/player recurring (27% of reported knee injuries) during the season. Games accounted for 56.4% (56/101) of reported knee injuries. Coaches generally believed that LPKB usage prevented knee injuries (56.4%, 56/101) and allowed LPKB usage (92.1%, 93/101), however only 8.3% (8/101) required their wear (interior linemen 50%, linebackers 25%, entire team 25%). Interior linemen had the greatest number of knee injuries, followed by offensive backs and linebackers. Most knee injuries (81%, 208/257) were out 3-6 weeks or less, 64% (164/257) involved sprains or contusions, 38% (97/257) were treated surgically (alone or with rehabilitation) and 36% (92/257) were treated solely with rehabilitation. Total knee injury and reinjury incidence were underestimated compared to existing reports. Improved injury recording methods, and post-symposia coaches evaluation are recommended.

Over 1.3 million high school athletes, over 75,000 college athletes, and several hundred professional athletes compete in organized football programs annually.¹⁻³ Projections indicate that over 636,000 high school football injuries are

sustained annually to varying anatomical regions,⁴ with the knee being the most commonly injured region, accounting for 8% to 36% of total football injuries.^{1, 4-7}

Few previous reports have focused solely on knee injuries among high school football players.⁷⁻⁹ Cahill⁸ reported an inverse correlation between knee injury rate and pre-season conditioning. Pritchett^{7, 9} reported knee injury rate and type by analyzing the insurance claims of injured high school football players.

Lateral prophylactic knee brace research has been influenced by reports of high knee injury rates among football players,^{1, 6, 10-12} however epidemiological and biomechanical reports on their efficacy have generated mixed results.¹³⁻¹⁷ Several authors have not only reported lateral prophylactic knee bracing ineffectiveness, but also relationships with increased knee injury rates and severity.^{18, 19}

Differences in the injury reporting systems have created a lack of a uniform injury definition, with differing authors classifying injuries by severity,^{6, 20} class,^{21, 22} and time loss.²³⁻²⁶ Also, differing methods have been employed for gathering data such as examining insurance claims,^{7, 9, 27} direct coach interviews,¹⁶ athletic trainer reports,^{21, 28} injured player interviews,¹⁰ post season mail-in surveys,⁵ and clinic treatment records.²³

The purposes of this survey were to: (1) determine the knee injury occurrences and knee injury recurrences of high school football players in Kentucky as determined by coaches' responses; (2) relate knee injury occurrence reports to initial care provider, treatment following initial physician exam, time lost from knee injury, knee injury type, player position, and team size; and (3) assess the opinions and practices of Kentucky high school football coaches regarding the effectiveness and appropriate use of lateral prophylactic knee braces.

From the Sports Medicine Section, Department of Orthopaedic Surgery, University of Kentucky, Lexington, KY 40536-0284 (Mr Stocker and Drs Nyland and Caborn); Tallahassee Orthopaedic Clinic, Tallahassee, FL (Mr Sternes); and Central Florida Orthopaedics, Clermont, FL (Dr Roy).

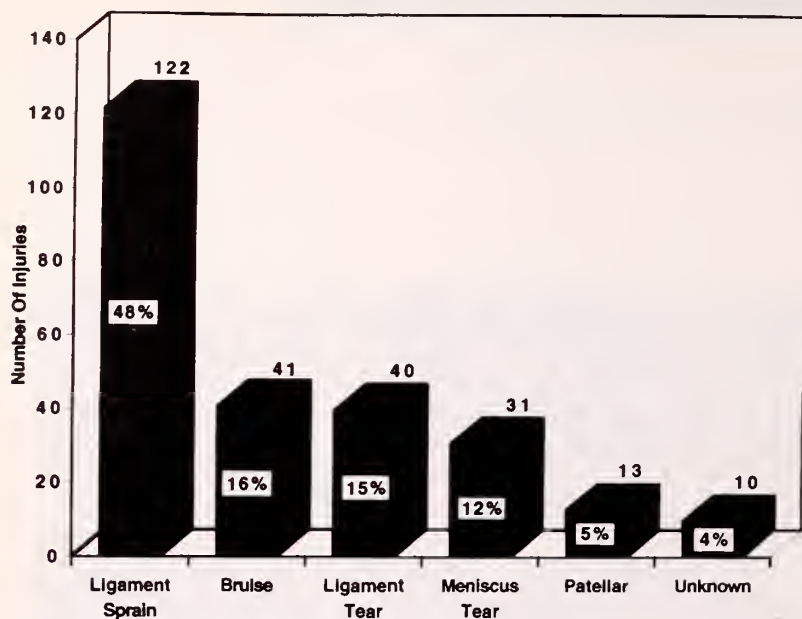


Fig 1 — Distribution of Knee Injuries by Type.

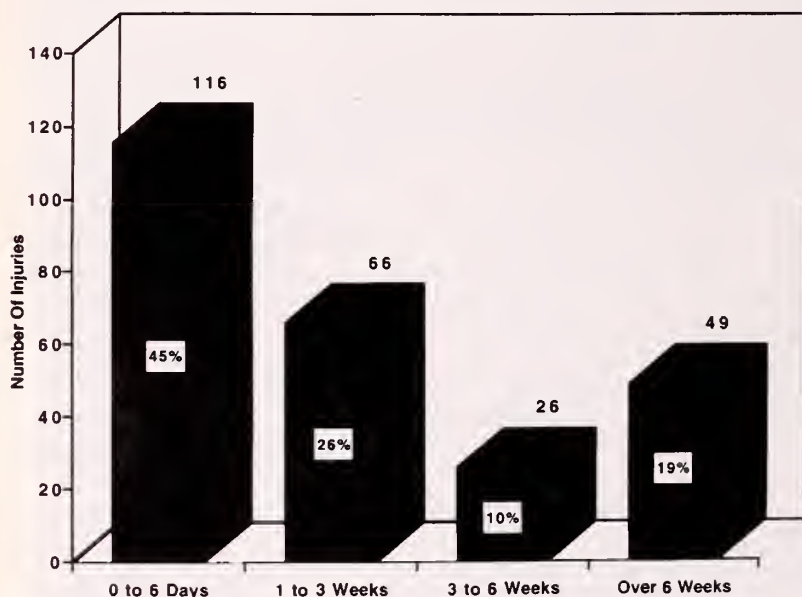


Fig 2 — Distribution of Knee Injuries by Time Loss.

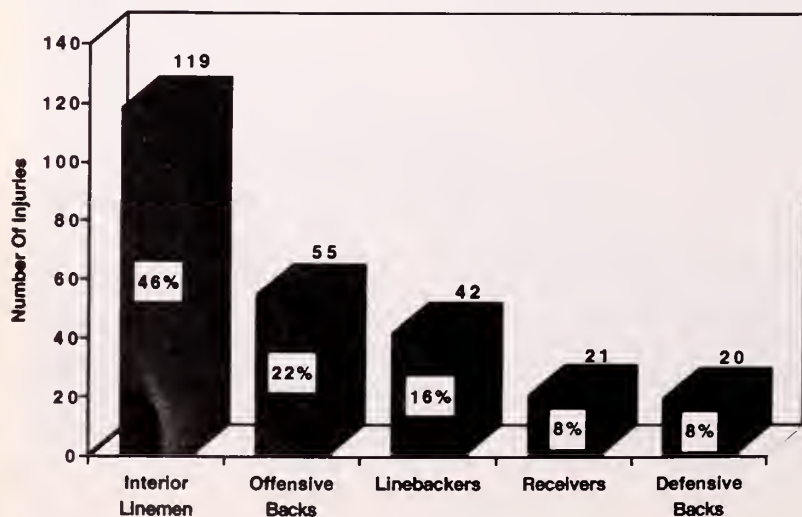


Fig 3 — Distribution of Knee Injuries by Player Position.

Methods

Coaches were asked to identify knee injuries which forced players to miss a football practice or game. In choosing a time loss injury definition, attention was focused on injuries considered likely to adversely affect athletic performance. Although there are limitations, the time loss definition seems to be the most popular and most uniform definition of injury currently available.^{29, 30}

The University of Kentucky Sports Medicine Center conducted a post season, mail-in survey of head high school varsity football coaches to accrue knee injury data and the perception of these coaches regarding the use of lateral prophylactic knee bracing (Appendix 1). Surveys were mailed to the head football coaches at each of the 201 high school football programs in Kentucky at the completion of the competitive season. Coaches were asked to include varsity players (grades 9–12) in their responses. All Kentucky high school coaches receive mandatory annual instruction in basic athletic injury management including knee injury mechanisms, classifications, and bracing from Kentucky High School Athletic Association (KHSAA) sponsored sports medicine symposia.

Statistical Methods

Descriptive statistics were performed using SAS version 6.07 software (SAS Institute Inc, Cary, NC).

Results

Approximately half (50.2%, 101/201) of the surveys were completed and returned. These 101 surveys represented a total of 4690 varsity football players with an average team size of ($x \pm SD$) 43 ± 13 players. A total of 257 knee injuries were reported, yielding .055 knee injuries/player, with .04 classified as "new" and .015 classified as recurring, or having occurred to an athlete that had already sustained at least one knee injury that season. Therefore, 26.5% of reported knee injuries were recurring injuries.

Of the reported knee injuries, 145 (56.4%) occurred in games and 112 (43.6%) occurred in practice. Knee injuries were classified by type (Fig 1), time loss (Fig 2), player position (Fig 3), initial care provider (Fig 4) and treatment mode following initial physician examination (Fig 5).

Most coaches believed that wearing a lateral prophylactic knee brace helped prevent knee injuries (56.4% versus 21.7%). While most coaches

(92.1%, 93/101) allowed lateral prophylactic knee braces to be worn by their players, only 7.9% (8/101) required their wear. Coaches who required lateral prophylactic knee brace use, generally required them for interior linemen (50%), interior linemen and linebackers (25%), or the entire team (25%).

Discussion

Analysis of 4690 Kentucky High School football players via post season mail-in surveys indicated a knee injury rate which was lower than previous reports (Table 1). In a random study of 216 Michigan high school football teams, Redfearn reported that 52% of the larger "A" schools and only 8% of the smaller schools had a team physician under contract.³¹ Not surprisingly, 70% of all high schools relied primarily on coaches for medical guidance. This study found that physicians (50%, 50/101) were the predominant initial knee injury care provider, followed by athletic trainers (23%, 23/101). Although the burden of responsibility for initial knee injury care for most of our high school football players generally falls upon coaches,¹¹ knee injuries appear to warrant greater consultation from athletic health care professionals.

We believe that the relatively low knee injury rate reported in this study was related to our injury identification method which required coaches to recall the knee injuries of individual players over an entire season. Garrick et al²⁸ reported that high school football coaches recognize about 85% of game injuries, but less than 45% of practice injuries, which means that many injuries (particularly practice injuries) go unrecognized and therefore untreated. Also, relatively lower overall injury rates have been reported through the use of post season, mail-in surveys.^{5, 11} Understandably, coaches seem more likely to report "memorable" traumatic knee injuries than nagging overuse or recurring knee injuries. High school football programs which have the benefit of certified athletic trainer services (for practices in addition to games) or coaches who are more educated in sports injury care are more likely to record accurate injury rate data.¹¹ Previous studies have reported that football coaches who had taken a first aid or an athletic training class reported higher overall injury rates than coaches who had not (55.7% vs 44.6%).¹⁰

Although previous reports supporting lateral prophylactic knee brace usage among high school

football players could not be found,³² slightly more than half (56.4%) of Kentucky head high school football coaches who responded to this survey supported their use, while 7.9% (8/101) required their wear. This agrees with existing literature which remains equivocal regarding the efficacy of

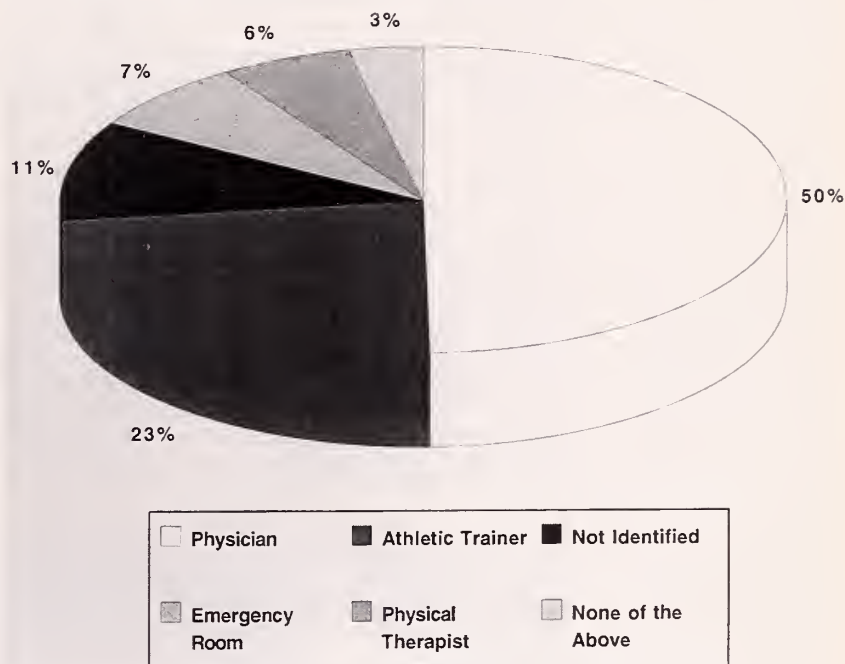


Fig 4 — Distribution of Initial Care Providers.

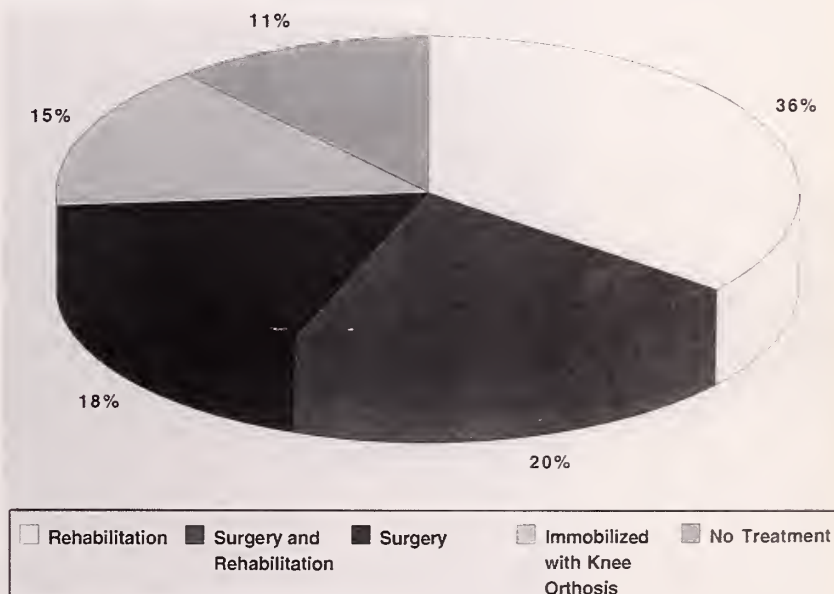


Fig 5 — Distribution of Treatment Mode following Initial Physician Examination.

Kentucky High School Football Knee Injury Survey

lateral prophylactic knee brace use for decreasing knee injury incidence among football players.

The KHSAA began implementing mandatory biannual sports symposia for coaches in 1987. These symposia were designed to provide coaches with current basic information regarding athletic injury mechanisms, first aid, nutrition, taping and bracing, and training/conditioning principles. Unfortunately, neither basic athletic injury documentation methods, instruction regarding the importance of athletic injury documentation, or encouragement to improve documentation are presently provided to coaches at these symposia.

Injury surveillance data acquisition would prove useful to and will inevitably become mandatory for managed health care agencies during these times of evolving health care reform. Innovations in computer and modem technology should ease the difficulties of performing epidemiological studies of high school football players and enable prospective injury studies while also fostering coach and health care professional interaction regarding athlete care issues.

Previous reports of knee injury type, time loss from knee injuries or knee injury rates/player position for high school football players were not found. This study revealed that recurring knee injuries accounted for 26.4% of all reported knee injuries. This finding is consistent with the recurring knee injury rates reported by Pritchett²⁷ (27.2%), and Moretz et al¹² (32%) among similar populations. These findings suggest that previously injured athletes may have returned to play before they were completely rehabilitated. The contention of Robey et al that 71% of primary athletic injuries will recur should raise further concern among high school football health care providers.

This study revealed that more knee injuries occurred during games than during practice. This finding is in agreement with the majority of previous reports of overall high school football injury rates,^{1, 6, 10-12, 23, 33} although it is commonly agreed that injuries which occur in practice are more likely to go unreported (Table 1).

Interior linemen sustained the greatest number of knee injuries, followed by offensive backs

Table 1. Comparative High School Knee Injury Percentage Studies

Investigators	Region	Data Source	Study Sample	Knee Injury Percentage
Stocker et al 1996	Kentucky	Coaches Survey	101 Schools, 4690 Total Players	5.5%
Neilson 1933 ⁵	California	Coaches Survey	281 Schools, 13,559 Total Players	8.7%
Hale et al 1981 ²⁴	Hawaii	Coch or Athletic Trainer Survey	885 Injured/ Non-Specified Total Players	13%
Pritchett et al 1988 ⁹	7 Western States (AZ, CA, ID, OR, NV, UT)	Insurance Claim Form Review	11,706 Total Injured Players	14.3%
Pawell et al 1987 ⁴	U.S.A.	Athletic Trainer or Paramedic Survey	6,544 Total Players	14.6%
Lackland et al 1982 ³³	South Carolina	Coch or Athletic Director Survey	19 Schools, approximately 950 Total Players	17.2%
Blyth et al 1974 ¹⁰	North Carolina	Direct Interview	45 Schools, approximately 9000 Total Players	19.3%
Booher 1976 ¹¹	South Dakota	Coaches Survey	162 Schools, 5326 Total Players	19.8%
Delee et al 1992 ¹	Texas	Athletic Trainer Reports	100 Schools, 4399 Total Players	20%
Moretz et al 1978 ¹²	Oklahoma	Coach Interview	7 Schools, 903 Total Players	22%
Culpepper et al 1983 ²³	Alabama	Clinic Treatment Records	1,877 Injured Players	22.2%
Olsen 1979 ⁶	Washington	Coach or Athletic Trainer Injury Reports	6-9 Schools, approximately 4500 Total Players	36.5%

and linebackers (Fig 4). Certainly the agility demands of the offensive back and linebacker during sudden directional changes are substantially greater than those of interior linemen. Also, these demands relate much more to non-contact related anterior cruciate ligament injury than the relatively more sagittally oriented movement demands of interior linemen. Because of the interior lineman's size, proximity to his opponent, blocking and tackling techniques and comparatively more fixed foot positions, it is not surprising that this position is more prone to contact related knee injuries (probably of valgus stress to the medial collateral and anterior cruciate ligaments). We must emphasize however that this number may be inflated because of the greater number of interior lineman compared to other player positions.

This investigation found that 81% of reported knee injuries were out for 3 to 6 weeks or less, 64% represented contusions or sprains, 38% were treated with surgery (alone or with rehabilitation) and 36% were treated solely with rehabilitation. Pritchett^{7,9} has reported similar rates (33% to 37%) of surgical knee injury management among high school football players. Since the majority of reported knee injuries appear to be non-operative, proper management largely depends on effective rehabilitation and functional return to play readiness evaluation. Coaches may need to receive more instruction in foundational functional movements such as the basics of normal walking gait and "pain-free" slow-to-fast functional movement progressions which appreciate proprioception. We have observed that football coaches too often equate rehabilitation solely with weight training and confuse the concepts of conditioning and rehabilitation. Establishing a better understanding of functional movement progression principles which eventually serve as return to play criteria may enhance the coaches' understanding of why players are or are not ready to safely return to action.

Budgetary "cut-backs" in health care, as in other industries have become common throughout the entire nation, and Kentucky is no exception to this trend. The large percentage of rural population (48.2%) in Kentucky often necessitates that high school football athletes travel considerable distances to be treated by health care professionals. Greater use of technological innovations such as computerized telementoring^{34,35} may both improve injury surveillance data acquisition and serve as an instructional media, fostering improved

communication between coaches, family members and athletic health care professionals. Regardless of mode, we believe that organized instruction such as that provided by KHSAA symposia should be followed by short and long term evaluations to discern how much information was both understood and implemented.

ACKNOWLEDGEMENTS: The authors would like to recognize the contribution of Linda Prang, MS, to the statistical analysis portion of this study.

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Kentucky High School Football Knee Injury Survey

Appendix 1.

Kentucky High School Football Coaches Knee Injury Survey

1. The total number of varsity players on my team. _____
2. The total number of knee injuries occurring to the members of my team which resulted in missed practices or games. _____
3. How many of these injuries are reoccurring? For example: A player with a sprained knee at a later date sprains the same knee again. _____
4. How many of these injuries involved a: (Please write in the number of athletes who sustained this particular injury)
 - a. partially sprained ligament _____
 - b. ligament completely torn _____
 - c. meniscus/cartilage tear _____
 - d. dislocated or fractured knee cap _____
 - e. bruise/cantusion _____
 - f. undetermined _____
5. How many injuries occurred to athletes of the following positions?
 - a. interior linemen _____
 - b. linebackers _____
 - c. defensive backs _____
 - d. offensive backs _____
 - e. receivers _____
6. How were these injuries treated?
 - a. surgery _____
 - b. rehabilitation _____
 - c. both surgery and rehabilitation _____
 - d. immobilized in knee arthrosis by a physician _____
 - e. no treatment _____
7. How many of the previously reported injuries originally occurred at practice or during a game?
 - a. game _____
 - b. practice _____
8. How many athletes with knee injuries were initially treated by the following athletic health care providers?
 - a. physician _____
 - b. athletic trainer _____
 - c. physical therapist _____
 - d. emergency room personnel/paramedic _____
 - e. were not treated by any of the above _____
9. Of all the players who had sustained knee injuries, how many missed,
 - a. 1-7 days of activity _____
 - b. 1-3 weeks of activity _____
 - c. 3-6 weeks of activity _____
 - d. longer than 6 weeks of activity _____
10. Do you personally believe that lateral prophylactic knee braces are beneficial for preventing knee injuries?

YES _____ NO _____
11. Do you require any of your football athletes to wear this type of knee brace?

YES _____ NO _____
12. If you answered yes to question #11, which athletes are required to wear this type of knee brace?
 - a. entire team _____
 - b. interior linemen _____
 - c. linebackers _____
 - d. defensive backs _____
 - e. offensive backs _____
 - f. receivers _____
13. Is lateral prophylactic knee brace use optional for your team?

YES _____ NO _____

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Prolymphocytic Leukemia: Diagnosis and Treatment A Case Report

Cem Akin, MD, PhD; Patricia Hansen, MD; Anthony Janckila, PhD

A patient with B-cell prolymphocytic leukemia (PLL) who has had a prolonged survival is presented. The patient was diagnosed incidentally while asymptomatic, but later developed progressive disease. He was refractory to alkylating agents and fludarabine, but responded to treatment with cyclophosphamide, doxorubicin, vincristine, and prednisone. This patient's prolonged survival may be due partly to his diagnosis at an indolent phase, possibly representing the early phase of the natural course of the disease. Diagnosis, clinical course, and treatment options for PLL are discussed.

Chronic lymphocytic leukemia (CLL) is a hematologic malignancy with protean clinical and hematologic manifestations.^{1,2} Patients with this disease may be critically ill at the time of presentation, or they may live for many years completely asymptomatic. These differences in clinical features and patient survival may be due to the extent of the disease at diagnosis, or to differences in the subtypes of CLL. CLL can involve lymphocytes of any specific type at any stage of maturation. Diagnosis of CLL should include staging and subclassification of the disease since the subtype is important to establish both a prognosis and optimal treatment. Prolymphocytic leukemia (PLL) is a variant of CLL which is distinguished by certain morphologic, phenotypic features of the leukemic cell, and clinical features of the patient.¹⁻⁴ Leukemic cells in PLL often show signs of transformation, including large size, abundant basophilic cytoplasm, and prominent nucleoli. Patients with PLL are typically refractory to traditional therapies for CLL, and have short survival. The natural course of PLL is not clear, although most patients are symptomatic at the time of diagnosis, and respond poorly to treatment.⁴

In this report, we present a patient who was

diagnosed to have de novo B-cell PLL. This patient demonstrated the typical features of PLL, but is still alive with stable disease 5 years after the diagnosis. Since the patient was diagnosed early, has survived long, and responded to cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP), analysis of this case may provide insight into the natural history of PLL, and reveal additional treatment options for the disease.

Case Report

In May 1991, a 60-year-old male was discovered to have an elevated white blood cell count with extreme lymphocytosis. The patient denied fever or weight loss. Physical examination was unremarkable. The liver span was approximately 10 cm, the spleen could not be palpated, and there was no lymphadenopathy. Radiographic study of the chest and electrocardiography were both unremarkable. Computed tomographic scan of the abdomen confirmed the physical findings; no organomegaly or adenopathy was noted. A complete blood cell count revealed a hemoglobin of 17.4 g/dl, hematocrit of 51%, leukocyte count of $18.5 \times 10^9/L$, and a platelet count of $179 \times 10^9/L$. The peripheral blood smear showed greater than 60% prolymphocytes. A sternal bone marrow aspirate was obtained and smears showed approximately 30% lymphocytes, most of which were small cells. Only a few atypical lymphocytes with lobulated nuclei were noted. Results of additional laboratory tests included a normal SMA-20, negative Mono spot test, and negative direct and indirect Coombs tests. Flow cytometric analysis of the peripheral blood cells revealed a predominant population of B lymphocytes expressing CD19, CD20, HLA-DR, and CD5. The cells also expressed intense surface IgD and IgM, with less than 1% expressing IgG.

The patient was asymptomatic and was fol-

From the Medical Service, Department of Veterans Affairs Medical Center, and the Department of Medicine, University of Louisville, Louisville, KY. Supported by the Research Service of the Department of Veterans Affairs, Washington, DC.

Prolymphocytic Leukemia

lowed as an outpatient in the hematology clinic. In September 1992, the patient's leukocyte count rose to $69 \times 10^9/L$, his platelet count decreased to $89 \times 10^9/L$, and his spleen tip became palpable. He was treated with three courses of chlorambucil and prednisone, but failed to respond. In March 1993, his WBC count rose to $143 \times 10^9/L$ and his spleen was progressively enlarged. The patient was treated with two courses of fludarabine, but again did not respond. In May 1993, his WBC count was $147 \times 10^9/L$, his platelet count was $41 \times 10^9/L$, and massive splenomegaly was noted. Splenectomy was performed. Subsequently, the patient's WBC count declined to $85 \times 10^9/L$ and his platelet count normalized. In August 1994, his WBC reached a nadir of $43 \times 10^9/L$. The patient remained stable clinically and hematologically until August 1995 when his WBC rose to $263 \times 10^9/L$ with 99% prolymphocytes (Fig 1a), and his platelet count fell to $52 \times 10^9/L$. There were still no palpable lymph nodes. Chemotherapy with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP), was begun. After six rounds of CHOP in April 1996, his WBC fell to $45 \times 10^9/L$. The patient remains stable.

Discussion

Prolymphocytic leukemia is a rare, subacute leukemia, which can occur de novo or as a result of prolymphocytic transformation from chronic lymphocytic leukemia.^{1,2,4} Although most cases are of B-cell origin, approximately 20% are of T-cell type, which carries a poorer prognosis.

Clinical features typical of B-cell PLL include, massive splenomegaly, absence of prominent lymphadenopathy, high leukocyte count (usually exceeding $100 \times 10^9/L$), normochromic normocytic anemia, thrombocytopenia, and poor response to chemotherapy.⁴ Patients are usually symptomatic at the time of diagnosis. The most common symptoms on presentation are fatigue, weight loss, and left upper abdominal discomfort due to splenomegaly. Splenic irradiation or splenectomy may provide temporary control of anemia and thrombocytopenia.⁵ Median survival for B-cell PLL is reported to be 3 years; survival exceeding 5 years is extremely rare.

There is no cure presently for PLL. Standard chemotherapy regimens used for CLL which contain an alkylating agent (chlorambucil or cyclophosphamide) and prednisone, with or without vincristine, are typically ineffective for PLL. Among the chemotherapeutics shown to induce partial or

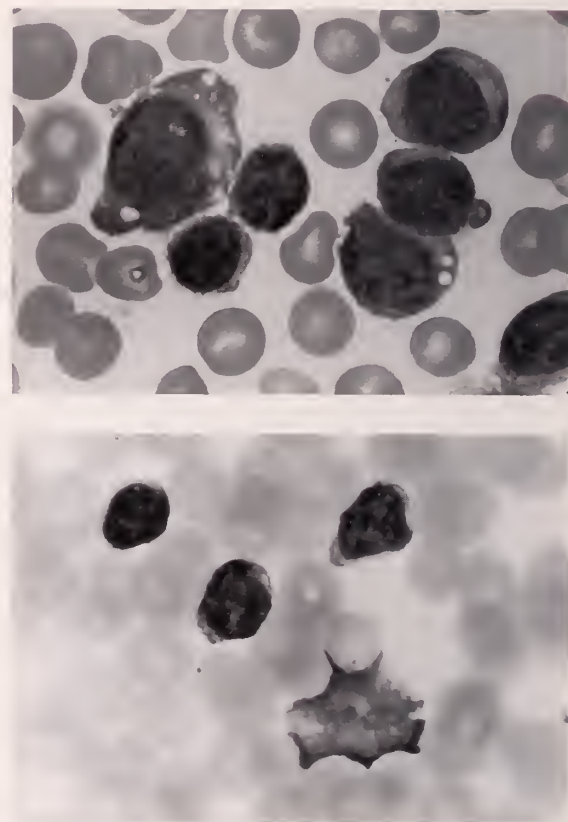


Fig 1—(a) Peripheral blood smear from our patient with PLL. Many leukemic lymphocytes possess the characteristics of prolymphocytic transformation including moderate to large size, abundant basophilic cytoplasm with vacuoles and nucleoli (Wright-Giemsa $\times 1320$). (b) Peripheral blood smear from a typical case of chronic lymphocytic leukemia showing small mature lymphocytes with "smudge" cells (Wright-Giemsa $\times 1320$).

complete remissions in PLL are fludarabine,⁶ interferon alpha,^{7,8} pentostatin,^{9,10} 2-chlorodeoxyadenosin,^{11,12} and combination therapies with an anthracycline containing compound, such as CHOP.¹³

Treatment of PLL with CHOP was first introduced by Catovsky for a patient with "lymphomatous deposits" in the liver.¹⁴ Although total clearance of prolymphocytes from blood was achieved, subsequent clinical course was not discussed. Later, Sibbald and Catovsky¹⁵ used eight courses of CHOP to obtain a complete remission in a patient with PLL who failed to respond to chlorambucil and prednisone. The patient was disease-free 2 years after the diagnosis; 1 year after chemotherapy. Two more patients who failed to respond to cyclophosphamide, vincristine, and

prednisone, and splenectomy, responded well to treatment with doxorubicin containing regimens.¹⁶ Interestingly, all patients in these case reports developed lymphadenopathy after splenectomy, which resolved upon CHOP treatment. Swift, et al¹⁸ described a patient who presented with no splenomegaly or lymph node involvement and was started on CHOP treatment after the diagnosis of PLL was established. Although a partial remission was obtained after three courses of therapy, the patient developed splenomegaly and became refractory to treatment, necessitating splenectomy. The patient remained well for 16 weeks, then developed adenopathy and fatigue. He responded favorably to L-asparaginase, but died suddenly of intraalveolar hemorrhage. From a review of the literature it appears that combination chemotherapy including anthracyclines can provide a sustained, measurable response in PLL.

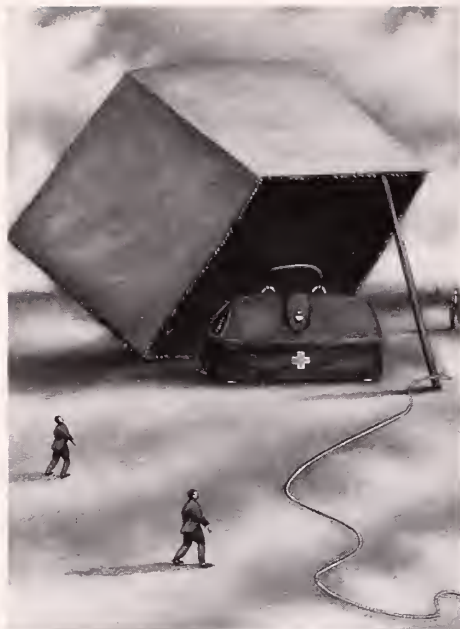
Our patient displayed several characteristic features of PLL such as splenomegaly, lack of adenopathy, high leukocyte counts, poor response to treatment with alkylating agents, and a transient response to splenectomy. It is noteworthy that the disease was discovered in an asymptomatic patient and remained indolent for several months before requiring treatment. This indolent phase may, in fact, represent an early stage in the natural course of the disease. In the original series by Galton et al¹ two of the 15 patients were diagnosed with PLL incidentally during investigation of unrelated problems. Those patients were still well, with only mild peripheral lymphocytosis, approximately 1.5 years after the diagnosis. In contrast, 6 of the remaining 13 patients who were diagnosed at the symptomatic stage, died within 16 weeks. Only 5 patients survived 1 year. Markey et al¹⁹ described two cases of T-cell PLL with protracted courses who survived 6 and 8 years after the lymphocytosis was noted, and who remained asymptomatic for 30 months, and 6 years, respectively, before treatment was initiated. The course of B-cell PLL in our patient also suggests that there may be an indolent, slowly progressing phase with minimal bone marrow involvement and mild lymphocytosis which precedes the symptomatic phase when most patients are diagnosed. Since PLL is already a rare disease, incidental discovery at an asymptomatic phase would be extremely uncommon. Prognosis becomes worse after the disease progresses into a symptomatic phase. Therefore, the time of diagnosis may carry important implications for the treatment and overall prognosis of PLL. Our patient is one of the rare cases in the literature who has

survived for 5 years or more. It is possible, however, that he may become refractory to CHOP treatment in the future. If so, 2-CDA will be considered as the next line of treatment.

ACKNOWLEDGMENTS: The authors thank Dr Lung T. Yam for permission to study his patient and for his valuable discussions and guidance, and Dr Lourdes Corman for her encouragement and criticism of our manuscript.

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Interprofessional Code

Kentucky Medical Association and Kentucky Bar Association

Preamble

Revised October 16, 1984

General Principles

Doctors of medicine and attorneys at law, as members of two professions possessing a close personal relationship with those they serve, have established principles of ethics applicable to the traditions and requirements of their respective callings.

The physician has responsibility for the care of the individual, in health as in disease. He must minister to his patient's needs to be best of his ability and in accordance with the high precepts of the Hippocratic Oath.

The attorney is an officer of the court, sworn to support the Constitution of the United States and of the state or states in which he is admitted to practice. As is the physician, he also is pledged to maintain the confidence and to preserve inviolate the secrets of his clients. He will not reject, from any consideration personal to himself, the cause of the defenseless or oppressed, nor delay any man's cause for lucre or malice.

The attorney represents his client as advisor and confidant, as his advocate in legal proceedings and as negotiator in the business and personal affairs of his client. The physician's relationship is parallel, for he is also the advisor and confidant of his patient in matters of health.

Interprofessional Relations

Each profession is obligated by its own stature to respect and honor the calling

of the other. Neither the fact nor the appearance of incompetence, corruption, dishonesty, or unethical conduct on the part of individual members of either profession can be tolerated. It follows then that each profession must vigorously support within its own ranks, as well as in the ranks of the other, those ethical concepts which each has found necessary in the public good. One who has chosen to be a physician or an attorney and has been found competent to be such by appropriate authorities, is vested with high responsibilities and privileges to enable him to serve the public with honor, with dignity, and with effectiveness.

This Code

A statement of ethical principles states a guide to the attainment of the best in interprofessional conduct and practices. IT IS NOT NECESSARILY OF A BINDING CHARACTER, NOR CAN IT BE SO DETAILED TO COVER EVERY CIRCUMSTANCE.

This Interprofessional Code constitutes the further recognition that with the great developments in the science and art of both medicine and law, it is inevitable that the physician and the attorney are drawn into steadily increasing association, as the law calls with increasing frequency upon medicine for its scientific knowledge and for its evaluation of facts so that the rights of individuals and of the government may be appropriately determined before various tribunals.

I. RECIPROCAL DUTIES

A. The Attending Physician and His Patient

The medical profession affirms the obligation of a patient's attending physician to cooperate willingly with the patient's attorney in supplying facts, primarily available only to him. The physician should accept the further responsibility of explaining such facts in such a manner that the attorney understands them and can determine their relationship to his client's cause. There should be complete cooperation between the physician and the attorney, each assuming his proper responsibility.

It is for the physician to determine the actuality or probability of fact pertaining to his patient's medical condition. It is for the attorney to determine how and under what circumstances such facts are to be appropriately presented.

A physician should never advise on the amount of damages a patient should seek to recover. The proper province of his professional advice is the extent, degree, or percentage of illness, injury, disability, or similar judgments based upon his professional knowledge of the case. He is not expected to understand technical rules of legal liability, or evidence, or of trial techniques. The latter are the exclusive province of the attorney.

B. The Attorney and His Client

It is a part of the attorney's oath on his admission to the bar of this state that he will not counsel or maintain any suit or proceeding which shall appear to him to be unjust, or any defense, except such as he believes to be honestly debatable under the law of the land. He will employ, for the purpose of maintaining the causes confided to him, such means only as are consistent with truth and honor and will never seek to mislead the judge or jury by any artifice or false statement of law or fact.

In discharge of that oath, it becomes the attorney's responsibility to marshal the facts and to obtain professional and other opinion which, in his judgment, are necessary for his client's case and in a manner consistent with his oath and the ethics of his profession.

It is important that the physician understand that legal proceedings in this country are conducted under what is known as the "adversary system." Under that system the attorney occupies a dual position. He is not only an officer of the court. He is also the single-minded advocate for his client. He does not and cannot properly represent both sides to a dispute.

This system has developed in recognition of the truth demonstrated countless times that justice can usually be satisfactorily accomplished if the two or more contestants can present their point of view to some neutral third person who can weigh the opposing claims. Such claims are usually presented in the form of testimony which is offered in question and answer form. The judge of a court or the officer presiding before an administrative tribunal is the referee who weighs the opposing points of view and the conflicts in testimony. In a sense the judge or administrative officer much more nearly approximates the physician in objectivity. The physician well knows, however, that in some situations it is also possible for medical men to vary honestly and sincerely in their physical findings, their treatment, and their evaluation of illness or injury. In some types of court

cases the parties prefer to let a group of sworn but interested citizens, the jury, weight and "find" the facts.

II. MEDICAL EXAMINATIONS

(Requested by Attorneys or ordered by Court)

A. General

1. The law provides that a party to a lawsuit may be required to undergo a medical examination by agreement of the opposing attorneys or under a court order.

2. When an appointment is made for the medical examination of a person, the physician sets aside a part of his day for that purpose. It is, therefore, important that attorneys exert their best efforts to insure that such appointments are kept. The attorney for the party to be examined should give explicit instructions to such party that the physician must be notified in ample time should it become impossible for the party to keep the appointment.

B. Scope of Examination

1. The physician may take a history and perform such examinations as may be advisable in his judgment to formulate an informed opinion regarding the nature and extent of the party's medical condition.

2. Inquiries should not be made by the physician into matters not reasonably related to the legitimate scope of the medical examination.

3. The physician, following his examination, shall reduce to writing a medical report, following the outline set forth in Section III.B.5. herein. The original report shall be forwarded to the court or person requesting the examination, with copies as directed by the court or by the person requesting the examination.

III. WRITTEN MEDICAL REPORTS

(Prepared for Courts or Attorneys)

A. The Attorney

1. Requests for reports from a physician should be made in writing as soon as it is known that the information is needed. The request should be clear as to the specific information desired and the report should be prepared by the physician as promptly as possible.

2. If a report is requested on a physician's patient, the attorney must provide the physician with a written authorization from the patient.

B. The Physician

1. **Medical Records.** The physician must keep records adequate to supply a patient's attorney all pertinent information regarding the patient-client's medical history.

2. Requests for medical reports should be honored promptly. Undue delays in providing medical reports of bills bearing on a patient's legal rights may prejudice his case.

3. If a physician is unable to make a complete medical evaluation within the time required, he should notify the attorney. In this event, a preliminary report clearly designated as such may serve the attorney's needs until a complete evaluation can be rendered.

4. **Patient's Authorization.** The physician must have his patient's written authorization before releasing any report or test concerning the patient. Such authorization is not necessary when the person examined is not a patient of the physician, and the examination is made in connection with a legal claim.

5. **Content of Report.** The following, where applicable, should be included in the report:

- a. Time, date and place of first visit.
- b. Accurate history of the injury or medical condition, including preexisting disease or prior injury.
- c. Nature of examination and findings.
- d. Results of laboratory work, x-rays, and consultations.
- e. Opinion including, where possible, diagnosis and prognosis. **Upon request**, the opinion should also evaluate

future physical impairment, necessity for future treatment or surgery, the effect of aggravation of any preexisting disease or prior injury, and length of convalescence. The opinion should likewise include the physician's true opinion on the cause of the patient's condition, and the strength of his opinion in evaluating the cause. In this regard, he should consider and state all objective and subjective matters bearing on this opinion, including, where appropriate, his evaluation of the patient's candor when considered in the light of his own medical knowledge.

f. State if patient's condition is stationary, or if the patient is discharged.

g. Subsequent examination: Include complaints and evaluation of condition, nature of treatment, confinement to hospital or home, referrals to other physicians, patient's progress, results of x-rays, ECGs, EEGs, laboratory work and consultations, and a concluding diagnosis and prognosis (see Item e, above).

h. Enclose separately an itemized statement of medical expense to date. Omit charges for medical reports or attorney consultations or ANY REFERENCE TO INSURANCE.

i. Include estimate of cost of future medical care.

IV. CONFERENCES

The physician and the attorney should confer relative to the common problems presented in a particular case. Such conferences should be arranged well in advance of court or other hearing at the mutual convenience of each, in full appreciation that to each profession, time is of the utmost importance. No physician and no attorney should be required to spend unnecessary time in arranging or attending such a conference. The attorney who knows and understands the progress of his client's case, the conflict, if any, of its medical aspects and the probability of settlement or trial should determine the necessity of a conference.

It is unfair to the patient-client, the physician, and the cause of justice to present a medical witness who has not first conferred with the attorney and who, therefore, may lack a full appreciation of the significance to the case of the particular evidence he is being asked to give. It is equally obvious that the attorney is less able to represent the full interest of his client where he has not had the advantage of full conferences with the physician in advance of presenting the case.

V. DEPOSITIONS AND/OR COURT APPEARANCE

Our system of justice depends on being able to require any citizen's time at a judicial proceeding and to give testimony regarding the case. A conference should be held between the physician and the attorney proposing to call him as a witness at some time mutually convenient before the physician is to testify.

A. Court Testimony

Both parties recognize that when it has been determined that the just and proper effect of a physician's testimony cannot be obtained without an oral examination in court, there is a necessity for the dissemination of information of both professions concerning the time problems involved in court testimony. The Medical Association recognizes that the legal profession faces calendar problems, which include the uncertainty of dates in a fluid trial calendar. The Bar Association likewise recognizes that the physicians appointments are made in advance and that physicians are in addition faced with pressing medical problems which sometimes cannot be deferred.

1. Attorney's Duties:

a. The attorney should ascertain whether the physician will be available for a trial term prior to the date assigned for trial at that term. He should not order the attendance of a physician as witness unless necessary and in any case without prior notice and confer-

ence concerning the matters as to which he is to be interrogated unless both the attorney and the physician agree that such conference is unnecessary.

b. The attorney should write to the physician immediately following the docket call to advise the physician of the proposed trial date.

c. The attorney should keep the physician's office advised of the status of the docket and notify the physician as soon as possible prior to trial of the probable trial date.

d. In the event of settlement or postponement, the physician should be immediately notified of that fact.

e. The attorney should give the physician as much notice as possible of the time when his attendance in court is desired. Physicians should not be asked to appear until the attorney is reasonably certain that they will not have to remain at the courthouse more than a short period of time before being allowed to testify. When the physician enters the court room, he shall, through a court attendant, make his presence known to the attorney trying the case. The attorney shall endeavor to put the physician on the stand as soon as possible after his arrival in the court room subject to orderly and proper presentation of the case.

2. Physician's Duties:

a. The physician has a moral and ethical obligation to give testimony regarding his patient. If the physician undertakes the care of a patient and litigation ensues, the physician should recognize his responsibility to testify as to the medical condition of that patient, subject to the provisions of the Agreement.

b. When given adequate notice of the time when he will be called upon to testify, the physician should make himself available at that time, unless an emergency situation arises which precludes his appearance.

B. Depositions

1. Physician-Patient Privilege. Where testimony is given and docu-

ments are called for by counsel during the taking of depositions in personal injury lawsuits, the usual obligation of confidence in the physician-patient relationship does not exist, and physicians shall furnish any and all pertinent documents, reports, records, notes or x-rays regarding the patient which are requested by counsel for either party to the lawsuit.

2. Deposition Defined. A deposition is an official proceeding authorized by law whereby a physician may be required to give testimony and be cross-examined under oath outside of court before a court reporter who is a notary public and in the presence of attorneys representing the parties. He may be requested to produce pertinent medical records at the deposition hearing. He may also be requested to release the records, x-rays, ECGs, EEGs, etc to the notary public for duplication and return.

3. Time and Place. The time and place of the deposition should be set by agreement with the physician. Unless there is a compelling reason to the contrary, it should be taken at the physician's office **at the time agreed, keeping in mind that an attorney's time has the same value as a physician's.**

4. Subpoenas — Medical Records. Production of pertinent medical records may also be required by subpoena duces tecum served on the physician. That subpoena requires the physician to attend the deposition at the time and place stated in the subpoena, and there to produce the specified records.

5. If Attendance at Deposition a Hardship. If the time and place described in the subpoena for the deposition creates a hardship, the physician should immediately bring this fact to the attention of counsel taking the deposition.

6. Preparation and Deportment
a. The Physician. Since the testimony given at deposition hearings may be read at the trial, it is important that the physician prior to deposition pre-

pare himself as for trial and that his attitude and deportment at the deposition hearing be similar to that at trial.

b. The Attorney. An attorney should totally prepare his case from the medical-legal standpoint so that with a careful use of words he can reduce the area of misunderstanding. It is not proper for an attorney to seek to color the professional opinion of the physician. No attorney is justified in abusing, badgering or browbeating any witness, including a physician.

7. Familiarity with Records. The physician and the attorney should be thoroughly familiar with their own records and with other related records, including hospital charts and records, at the time the deposition is taken and should have as many of the records at the time the deposition is taken as is possible so that they may be referred to as needed.

8. Predeposition Conference. It is to be understood that it is proper to have a predeposition conference between the attorney for the patient and the physician to facilitate the taking of the deposition.

NOTE: If court testimony or a deposition of a physician cannot be set by agreement, the physician's attendance can be required by appropriate legal process. If any doubt arises as to the effect of such legal process, the physician should consult his attorney. A physician should not take offense at being served with a subpoena in the event an agreement cannot be made.

VI. COMPENSATION FOR MEDICAL REPORTS, DEPOSITIONS, COURT APPEARANCE AND OTHER SERVICES

It is impractical to establish precise rules governing a physician's fees for medical reports, reviewing medical records, conferences, opinions, depositions, court appearances, copies of medical records and other services. It is important, however, that fees be reasonable and that they be discussed in

advance by the physician and the attorney. In this way, the major cause of misunderstanding and dissatisfaction will be eliminated. Generally, the attorney who requests these services of a physician is primarily responsible for prompt payment of the physician's reasonable fees. **Under no circumstances may a physician charge a fee for such services which is contingent upon the result of the lawsuit.**

As a matter of policy an attorney should not request a physician to testify on deposition or in court, nor should he subpoena him, without making arrangements for reasonable compensation. This is not required by law, but is suggested as a matter of fairness and cooperation between the professions. A physician should be compensated for the time spent away from his professional practice, regardless of whether he is used as a witness.

VII. COMPENSATION FOR MEDICAL TREATMENT TO THE PATIENT

A. The patient, not his attorney, is responsible for paying all bills incurred by the patient for his medical care. While bills should be sent to the attorney on the attorney's request, this does not make the attorney responsible for their payment.

B. When the attorney first obtains a written authorization from his client for the release of medical information, the attorney should request his client to authorize the attorney to take out of the proceeds of any recovery by way of settlement or verdict the funds necessary to pay the physician's then outstanding bill for medical treatment. Upon such authorization being given, the attorney should so inform the physician. Upon recovery, if any, the attorney should, in every case, seek to protect the interest of the physician and see that the physician's bill is paid. In the event there is no recovery, or the recovery is insufficient to pay the bill, the attorney should

so inform the physician. (For suggested form, see Appendix A.)

APPENDIX A AGREEMENT TO PAY PHYSICIAN FEES

I, _____
hereby authorize and direct my
attorney, _____,
to pay promptly to _____, MD,
from my portion of the proceeds of
any recovery which may be paid to
me through my attorney as a result
of the injuries sustained by me
(and _____),
on _____, 19 _____, the
unpaid balance of any reasonable
charges for professional services ren-
dered by said physician and his asso-
ciates on my behalf, said profes-
sional services to include those for
treatment heretofore or hereafter
rendered to the time of the settle-
ment or recovery, as well as those
for medical reports, consultations,
depositions and court appearances
on my behalf. I understand that this
does not relieve me of my personal
responsibility for all such charges in
the event there is no recovery or if
the recovery is insufficient to satisfy
such charges.

DATED _____

Patient _____

APPROVED AND ACCEPTED:

DATED _____

Attorney _____

violations thereof by a member of either
profession should be brought to the at-
tention of the Physician-Attorney Liai-
son Committee for a determination to
be made as expeditiously as possible.

Notice of the nature and pendency
of the complaint shall be given to the
person about whom the complaint is
made.

IX. AMENDMENTS

This Code may be amended from time
to time upon joint resolution of the re-
spective associations represented
herein.

This code was originally imple-
mented by a joint committee of the Ken-
tucky Bar Association and the Kentucky
Medical Association in 1973.

The revised Interprofessional code
was approved in 1984 by the KMA
House of Delegates and the Board of
Governors of the Kentucky Bar
Association.

VIII. IMPLEMENTATION OF THE CODE

The purpose of this Code is to establish,
maintain and perpetuate a greater de-
gree of understanding and ethics be-
tween the respective medical and legal
professions. Any abuse of this Code or

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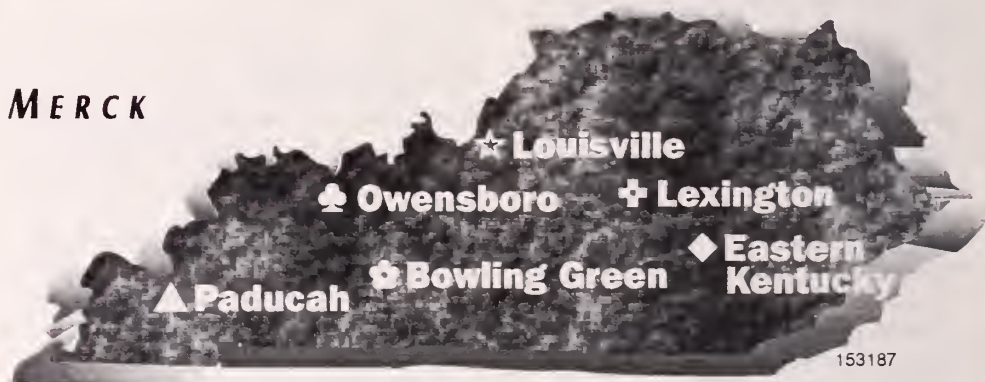


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The Coming Plague

Daniel Defoe wrote that the bubonic plague which decimated London in 1665, "... defied all application of remedies; ... the power of man was baffled and brought to an end. So the plague defied all medicines; the very physicians were seized with it, with their preservatives in their mouths." In like manner do we now find resurgence of old microbial pathogens and the emergence of new pathogens expressing antibiotic resistance that baffle us and incrementally defy all applications of our medicines. Since the introduction of sulfonamides in 1936, microbes have demonstrated an alarming and impressive genetic resiliency capable of thwarting virtually every new and modified class of antimicrobial. What began as an irksome dilemma of limited antibiotic resistance among far-flung operating theaters and intensive care units has blossomed to crisis proportions on a global scale involving communities and workplaces as well as hospitals.

Resistance patterns vary widely between hospitals, geographic regions, and the types of antibiotic regimens utilized. However, the increasing, and sometimes indiscriminate, use of antibiotics, the relative ease with which resistant pathogens spread in our modern global community, and the efficiency with which transferral of resistance genes occurs between bacterial communities portend the unsettling possibility of a coming decade of micro-organisms essentially resistant to all known antibiotics.

Consider several of these observations: The most frequently prescribed medication in 1996 was Amoxicillin. Over all, six billion prescriptions for antibiotics were

written last year, and approximately 75% of viral upper respiratory tract infections were treated with antibiotics. From 25% to 45% of all hospitalized patients receive antibiotics. In 1994, the Centers for Disease Control found that 61% of pneumococci isolated from children from one day care center in Kentucky were resistant to penicillin.

"The increasing, and sometimes indiscriminate, use of antibiotics, the relative ease with which resistant pathogens spread in our modern global community, and the efficiency with which transferral of resistance genes occurs between bacterial communities portend the unsettling possibility of a coming decade of micro-organisms essentially resistant to all known antibiotics."

Interestingly, the introduction of new antibiotics in animal feed lots and aquaculture often parallel the emergence of newly resistant, virulent pathogens among the local human population. Currently, vancomycin-resistant strains of certain bacteria and some strains of mycobacteria are already resistant to all available antibiotics.

Multi-resistant strains of most known pathogens are evolving at a rate beyond our capacity to develop new drugs or strategies. Among the gram-positive bacteria, multi-resistant strains of *Streptococcus pneumoniae* and the viridins group have been described along with strains of *Corynebacterium* which are resistant to all drugs except vancomycin. Methicillin-resistant *Staphylococcus aureus* (MRSA) has been susceptible to vancomycin until now, but vancomycin-resistant enterococci, especially *Enterococcus faecium*, have the potential to transfer mobile vancomycin-resistance genes horizontally (cross-species) to pathogens such as MRSA. Among the anaerobes, *Bacteroides* species have long been studied as models of antibiotic resistance. Gram-negative bacteria include increasing numbers of *Enterobacter*, *Escherichia coli* and *Klebsiella* species resistant not only to third generation cephalosporins but to clavulanic acid. *Proteus* and *Serratia* strains have been shown to express extended spectrums of β -lactamases and *Pseudomonas* has become progressively less treatable. Multiple drug resistances have also developed in *Citrobacter* and *Haemophilus* species, *Neisseria meningitidis* and gonorrhea and *Moraxella catarrhalis*. Recently, multi-resistant *Salmonella typhimurium* outbreaks occurred here and in the United Kingdom coincident with the introduction of fluoroquinolones and trimethoprim in cattle and poultry feed lots. And multiple drug resistant (MDR) *Mycobacterium tuberculosis* has been rapidly increasing, particularly among HIV patients.

In the case of industrialized countries, resistant bacterial pathogens often evolve in intensive care units,

where heavy use of antibiotics coupled with antibiotic combination therapy and ready transmissibility of bacteria are prevalent. In the community similar conditions are becoming evident in day care centers, nursing homes, prisons, farms, and feed lots. Among less well-developed countries, bacterial resistance is more frequently community-driven within areas of overcrowding, poor sanitation and availability of cheap, older, over-the-counter antibiotics.

Bacterial resistance genes ostensibly predated current pharmaceuticals by millions of years, possibly evolving as a defense against naturally elaborated antibiotics produced by competing bacterial populations. Though much remains to be understood regarding the mechanisms, resistance can be either intrinsic due to spot mutations or acquired. Intrinsic resistance derived from fortuitous mutations usually results in an enfeebled cell, is non-transmissible, and appears to have little clinical relevance. The majority of clinically challenging microbe resistance is acquired from readily transmissible bits of genetic material which is transferable to subsequent cells. There are three ways in which pertinent DNA sequences can be acquired by cells: obtaining a strand of DNA directly from another cell, from a plasmid, or from a transposon. Plasmids are autonomous, self-replicating circular strands of DNA which integrate into a recipient cell while transposons, or "jumping genes," are usually linear bits of DNA that integrate directly into cellular chromosomes or plasmids. Such DNA enters a cell either by transformation, an event whereby "naked" DNA directly enters a cell and rarely occurs in nature, by transduction whereby DNA is introduced into a cell infected by bacterial viruses, or phages, and most notably by conjugation, wherein stable cell to cell contact allows the interchange of plasmids or

transposons. More recently, Hall and Stokes described a novel and potentially disastrous vector of resistance genes transfer mediated by DNA elements coined "integrons." Basically, integrons are highly mobile DNA elements that encode not only genes for ready integration into other chromosomes but contain capture sites that can acquire a veritable library of independent "gene cassettes" each encoding a separate antibiotic resistance gene. Thus, a bacterium invested by such an integron-cassette library can literally acquire overnight a repertoire of multiple drug resistances, the consequences of which have

"Multi-resistant strains of most known pathogens are evolving at a rate beyond our capacity to develop new drugs or strategies."

obvious and profound implications.

Once a bacterium acquires a resistance gene, resistance to antibiotics is conferred by one of several, general mechanisms: the antibiotic can be modified or inactivated by enzymes encoded by the gene, the target molecule to which the antibiotic is directed can be altered such that binding cannot occur, overall decreased uptake of antibiotic or increased efflux of the drug by the cell negates its effect or an alternate target is synthesized that bypasses the inhibitory effect of the antibiotic. Overcoming such resistance is becoming increasingly difficult. No new class of antibiotics have been introduced since the fluoroquinolones in the 1980s, and newer quinolones utilize the same mechanism of bacterial DNA gyrase inhibition. Fewer therapeutic options are available in

part due to the expense of researching and developing new drugs combined with a misperception in the last decade that there was little necessity for developing new classes of antimicrobials. Various groups have been designated to study and give recommendations regarding this growing health concern, including the National Nosocomial Resistance Surveillance Group, the ICU Anti-microbial Resistance Epidemiology (ICARE) study and most recently, the Sentry Anti-Microbial Surveillance project, an ambitious and timely program headed by Ronald Jones, University of Iowa. Recommendations to date have ranged from the Semmelweisian proscription of thorough hand washing, maintaining restrictions of drug usage according to resistance patterns in each hospital, to cycling of antibiotics or altering dosing to maximize duration of antibiotic serum levels above the mean inhibitory concentration. However, the problem is far more ubiquitous than that, and solution involves the joint efforts of not only health care personnel, but a better-informed public, basic scientific research, and monitoring of antibiotic usage and resistance in the health care industry as well as in food production. Despite this, my own opinion is that the role of antibiotics is short lived and of necessity must yield to superior therapeutics involving the induction of immuno-competent cells, cytokines and growth factors, the direct alteration of the very genetic mechanisms that confer acquisition and transfer of resistance and a greater understanding and manipulation of the factors that dictate the biologic relationship of microbes to their host cells. Should we rely solely on restraint in the use of current anti-microbials, commendable hand washing techniques, and the good will of committees, we shall ultimately face a plague of truly biblical proportions.

Jaroslav P. Stulc, MD

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County Presidents-Elect at Confluence I



Aroona Dave

The weekend of September 28th-30th, Leadership Confluence, AMA Alliance at Drake, Chicago, was the place to be for your five County Presidents-Elect, your State Presidents-Elect, and your President. This was my fifth Leadership Confluence. I had a chance to listen to our confluence participants from Kentucky and this is what they had to say . . .

Becky Staten, Boyd County Medical Alliance President-Elect said, "It is very professional, highly organized and smoothly run." She also felt that National Resource Material will be helpful to her. Networking with County Presidents-Elect from other counties, exchanging ideas as to what works, these interactions have given her confidence about what she wants to do in her county.

Warren County President-Elect Tammy Bergamini has this to say, and I quote, "Magnificent, more than I ever expected. I wish all my county members will have the privilege of attending the Confluence and I would implement this enthusiasm, motivation and information on SAVE project! What can we do for the community???"

County President-Elect of Jefferson County Medical Alliance, Dianne Cox,

was overwhelmed by the Confluence. She thought it was well organized and everyone was friendly. Dianne received a better understanding of what Alliance is all about and about supporting SAVE.

Northern Kentucky Medical Society Alliance County President-Elect Connie Combs was energized and inspired by the Confluence Workshops, guest speakers, general sessions, and networking with the counterparts from across the nation. Connie was impressed by the fact that all the guest presenters were most dynamic, informative individuals in their fields. "There are no bad speakers here." Networking luncheon and outstanding information available from The Project Bank Catalogue will help her year as President. The focus on SAVE is her primary interest.

Fayette County Medical Auxiliary County President-Elect Debbie Adkins received an overwhelming wealth of information. Confluence was the great opportunity for networking. Debbie thinks she would like to take back the information on media violence and medical marriage. Parliamentary procedures will help her in her year to run things smoothly.

In conclusion, leaders came in all different styles. But all of them are committed to the Mission and Focus of the organization. They are motivated because they have the ability to lead. They listen, they readjust their attitude, and they are willing to learn. Leaders are effective because they understand. Their job is to delegate responsibility and get it done. They know the importance of working together.

Leaders are surrounded by other leadership to work, to move the organization forward. When you are asked to be involved in serving your Alliance, GET INVOLVED!

Fondly,

**Aroona Dave
KMAA President**

MEMBERSHIP: IT IS EVERYONE'S RESPONSIBILITY!

Audits, Investigations, and Serious Trouble

by Martha J. Hasselbacher and Marc S. Murphy

These are potentially dangerous times for physicians. The State's Medicaid Fraud and Abuse Investigation Unit is up and running. Governor Patton has stated that he fully intends to stop the illegal and inappropriate prescribing of narcotics. Attorney General Ben Chandler is forming a task force on the prevention of prescription drug abuse. New federal fraud and abuse laws have not only increased civil money penalties and jail time for criminal offenses, but also extended health care fraud actions to private payors. A pattern of inappropriate billing is now a felony punishable by a 10-year prison term. Millions of dollars from federal fraud settlements go into a fund which is used to finance further investigations. Never before have so many agencies been so interested in so many physician practices.

It is a mistake to read the newspaper headlines and think "I needn't worry because I'm no crook." In today's regulatory environment, apparently innocent mistakes or corner-cutting can be the basis for a criminal investigation or indictment. Do you and your office staff know how to cope with audits and investigations? Do you have procedure in place to deal with routine and non-routine inquiries? Do you know the difference between a warrant and a subpoena? Do you know what your rights are during an investigation? Can you tell the difference between a routine audit and an investigation which may lead to serious trouble? Do you think this only happens to "other" doctors and will never happen to you?

I. Audits

A. How Physicians Are Selected. It is a myth that only "bad doctors" are selected for audit. Ethical, honest physicians are also the subject of audits. Even if you believe your practice is audit proof, you may not be aware of problems engendered by billing agents, employees, or honest mistakes in the interpretation of laws that are increasingly complex and subject to change.

Often the reason for audit selection is dollars. The more successful the physician, the more likely an audit. All sophisticated third-party payors have computer systems which compare billings among physicians of the same specialty. Being a few standard deviations from the average practice in the computer profile either for number of visits under a certain CPT code or laboratory and other diagnostic tests may trigger an audit. However, statistical deviations do not necessarily mean that you are in trouble, just that the chance of an audit is increased. Often the reason for the deviation from the norm can be explained by the acuity of your practice or other factors.

Audits or investigations may also be initiated because of an informant. The state has a Medicaid Fraud Hotline. Typically, information comes from disgruntled employees, unhappy patients, competitors, or ex-spouses. New whistle blower provisions have authorized rewards for individuals whose reports lead to the recovery of claims. Government agencies are sharing information. Trouble with the

DEA or IRS may also trigger an investigation from federal or state fraud units and vice versa.

B. The First Visit.

Typically, the first visit begins innocuously and involves the copying of a relatively small number of medical records or a "Statistically Valid Random Sample." It is common for fraud investigators to describe their visit as "routine." The object of a "routine" audit (post payment review) is to identify inappropriate, medically unnecessary or excessive services. Medicare carriers may reopen claims submitted by providers "for any reason" within a 12-month period. Carriers may also reopen claims at any time up to 4 years "for good cause." Moreover, carriers are permitted to reopen claims "at any time" if fraud is involved. If the audit really is "routine," it may end here, perhaps with an over-payment letter for a few claims.

Obtain the name, title, and preferably the business card of the person who is conducting the audit. It is not adequate to be simply told that the person is from the carrier or from Medicare or Medicaid. Different agencies investigate different problems. At the outset, you must know if this is civil audit involving only dollars, or if there is the potential for a criminal indictment. If a state fraud unit, Office of the Attorney General, or the US Attorney and Office of the Inspector General are involved, there is the likelihood of criminal liability.

C. The Return Visit.

Once the medical records are copied,

they are reviewed by professionally trained medical personnel or experienced claims examiners using national coverage guidelines and local medical review policy. In the event that problems are found, there is a return visit. At this time there could be a request to copy more—as many as 100 to 200 medical records. Typical activities targeted by the government are:

- A. Billing for unperformed services;
- B. Upcoding of services performed;
- C. Cost report fraud (this may apply to rural health clinic practices);
- D. Billing for provided, but unnecessary services;
- E. Billing for teaching physician services;
- F. Separate billing for services which should be bundled.

The Medicare Carriers Manual provides a definition of "fraud or similar fault," which includes not only billing for services not rendered, but also various activities that "evidence a pattern of program abuse by physicians or suppliers resulting from practices that are inconsistent with accepted fiscal business or medical practice."

Even a return visit may only result in an overpayment letter. If the amount is large, the government can charge interest on the outstanding amount and may also impose civil money penalties. If you think that the government's interpretation of these claims is unjustified, you can challenge the validity of the government's position and negotiate the amount of overpayment due. The courts have upheld the government's use of a statistical sampling of a number of claims to project the number of inappropriate claims for your whole practice. Although the carrier is not authorized to conduct criminal investigations, the carrier will notify the Office of Inspector General and/or state fraud units if a routine audit uncovers a pattern of false or fraudulent billing.

II. Agents With Badges, Guns, and "Papers"

The director of the Federal Bureau of Investigation has stated that health care program fraud is "rampant" and costs Americans more than \$44 billion a year. In Chicago, the head of the local office of the Federal Bureau of Investigation recently stated that he was assigning 20 agents formerly assigned to cold war activities to health care investigations. Prosecutors believe that high profile criminal and civil investigations are cost effective and have a strong deterrent effect. The execution of search warrants, and to a lesser extent, the delivery of administrative subpoenas with a demand for immediate compliance, allow the government the opportunity to seize evidence and create an atmosphere of fear that some prosecutors believe enhances their ability to successfully bring charges.

A. What Search Document is Being Presented?

1. Subpoena

An agency subpoena or records request requires that you produce information, but does not allow the officers to search your place of business. A subpoena usually does not allow investigators to demand immediate, on-site delivery of the documents. Counsel should determine if the document presented by the investigators entitles them to search for the material requested, or to immediate possession of that material. Often the statutory authority granting the agency subpoena power will also allow you a reasonable time to produce the requested records.

2. Warrant

The strongest authority an investigator can present is a search warrant issued by a magistrate or judge. The warrant allows investigators access to the physical premises to seek evidence of suspected violations of the law. A search warrant (either federal or state)

allows the designated officer to seek and seize property that may constitute evidence of the commission of the alleged crimes described in the warrant. Counsel can supervise the search and raise issues of privilege, but in all but the rarest cases, the search will continue under a warrant. Failure to comply with the search warrant can lead to charges of obstruction of justice.

B. Who Is Conducting The Search?

It is important to know which agencies are conducting this search. The search may be exclusively federal, or it may be a cooperative effort between federal and state offices. It is common for either federal or state agencies to inform each other of an investigation and federal agencies will often tip off other federal agencies and invite them to join in an investigation. It is also quite common for any federal agency suspecting a large dollar amount health care fraud case to involve the Internal Revenue Service.

C. What Are Your Rights?

First, and most importantly, you have the right to counsel. Fight the urge to think "only the guilty need lawyers." You wouldn't let a patient take out her own appendix. You should not represent yourself in this, the most serious of legal matters. If you are the target of a criminal investigation, you have the right to remain silent and to not be questioned by the investigators without your attorney present.

You have a right to have the agents identify themselves. If your attorney is not present, obtain a business card from the agents in charge and make sure that you identify each agency involved in the investigation. You have a right to receive a copy of the documents that authorize the search and an inventory of all items taken during the search.

III. Practical Tips

- Involve an attorney immediately.

- Know what to do if auditors/investigators arrive unannounced. Make sure that your staff knows what to do and whom to call if you are unavailable.
- Cooperate with a carrier audit. As a condition of your participation in the Medicare and Medicaid programs, you have agreed to furnish whatever records necessary for plan compliance, quality assurance, and utilization review. Failure to provide requested records can result in your exclusion from these programs.
- Even for a routine audit, although you must provide the documents requested, you have no obligation to allow the auditor/investigator unlimited access to your staff, unless it is a criminal investigation. Designate one responsible employee (usually the office manager) to be the sole contact for the auditor. All other employees should be instructed to politely comply with requests, but refer all questions to this one employee. Any questions that are more than perfunctory requests for information should be

written down and taken to you for approval, or, if necessary, taken to your attorney before they are answered.

- Although investigators will often act as if employees must answer questions on the spot, employees have a choice whether or not to speak to investigators even in a criminal investigation. You may instruct employees that you are cooperating with the investigation and that it is their choice whether or not they choose to talk to the investigators. You should be aware that to instruct employees not to talk to investigators is an obstruction of justice. You should also be aware that if employees do not speak to investigators at the office, the investigators may approach the employees at home. If that employee's testimony is crucial to the investigation, the investigator may obtain either a summons or a subpoena for the interview.
- The best preparation for any of these contingencies is to ensure that your practice is in full compliance with all

federal and state regulations. If you suspect that you may have potential problem areas, consult with an attorney. You may wish to implement a self-auditing program with the help of an attorney to identify any potential problems and head off "serious trouble" before it reaches your practice.

The authors practice law with the firm of Stites & Harbison in Louisville. Martha Hasselbacher practices in the Health Law Section representing physicians and health care entities in Medicare/Medicaid payment issues, managed care contracting, physician practice/employment issues, credentialing, and health care regulatory litigation. Marc S. Murphy is a former federal and state prosecutor and specializes in private practice in white collar criminal defense. Prior to joining Stites & Harbison, Mr Murphy was Jefferson County (Louisville) Commonwealth's Attorney.

Diane M. Maxey Elevated to KMA Executive Staff



Diane M. Maxey was named KMA Director of Member Services on October 1. Having served as Manager, Membership Development since 1992, she will continue to be involved in all areas of membership recruitment, retention, and benefit programs for members. In addition, she will assume responsibility for KMA's CME program and the publication of the *Communicator*, as well as various committees within the KMA structure.

Ms Maxey first joined the KMA staff in 1969 as Assistant Managing Editor of the *Journal*. Since 1983, she has served in the membership area and has guided the activities of the Medical Student Section and Resident Physicians Section, as well as coordinated practice management programs for physicians and medical office staffs.

A Louisville native, Ms Maxey received a Bachelor of Arts degree in Journalism from Morehead State University. She is married, has two sons and one granddaughter, works with youth activities at her church, and teaches classes in English as a Second Language.

Actions of Reference Committee E (Science and Technology) AMA Annual Meeting, June 1997

This is the fourth in a series of articles from the members of your AMA delegation. The purpose of this series is to inform the KMA membership of the actions of the House of Delegates at the June 1997 Annual Meeting. This article reports on the items considered by Reference Committee E, which usually deals with issues of science and technology. The issues are always wide-ranging in this committee. The opinions of public health representatives and of the FDA are often important in the discussions.

Thirty-six items were considered including 9 reports and 27 resolutions. A summary of the House actions on these issues is included at the end of this article. Though many of the items on the list may seem esoteric, some physicians reading this article may find resolutions and reports that may be of specific interest to them.

Usually the reports are well-written and comprehensive, especially those generated by the Board of Trustees. Of the reports included here, Reports 5 and 6 of the Council on Scientific Affairs, on Attention Deficit Disorder and Osteoporosis respectively, are particularly well-written and informative. Board of Trustees Report 8 addresses the issue of standardizing international methodology for calculating infant mortality rates.

The original resolution 510 from the 1996 Annual Meeting, which led to

Report 4 of the Council on Scientific Affairs, sought to ease restrictions placed on ordering of restraints for nursing home patients. The CSA Report, however, reaffirmed Policy 280.987 which supports limitations on restraint use.

Reports 12 and 13 from the CSA are on Alternative Medicine and Folk Remedies. These two reports were actually reworked after presentation at the 1996 Interim Meeting in Atlanta. They still seem to leave much to be done in delineating policy on these issues of growing interest.

Resolution 510 entitled "Freedom of Speech in Medical Information" actually resolves AMA opposition to the Multi-District Litigation (MDL) pertaining to spinal pedicle screws, including filing as an *amicus curiae*. Resolution 501, "Diabetes Education by Pharmacists," is in regard to information supplied by pharmacists to patients and involves scope of practice issues. Resolution 525 addresses informing about and screening for iron overload.

Resolution 509, "Truth in Nutrition Labeling," requests listing of trans fatty acid levels on food labels. This was among the issues referred to the Board of Trustees. Also referred was 515 which asked that the AMA support a more stringent air quality standard for ozone. Similarly, 516 regarding airborne particulates was referred.

Cloning and embryo research (528) and Genetic testing (526) were discussed and referred to the Board of Trustees for further evaluation. Resolution 522 called upon the AMA to request the Council on Medical Services to review the Canadian Medical Association document, *The Physician's Role in Helping Patients Return to Work After an Illness or Injury*, and report back to the House of Delegates at the 1997 Interim Meeting. This was instead referred to the Board of Trustees for report back at the 1-97 Meeting.

J. Gregory Cooper, MD
AMA Alternate Delegate

REFERENCE COMMITTEE E

ADOPTED

1. Resolution 510—Freedom of Speech in Medical Information
2. Resolution 523—Caffeine Drinks
3. Council on Scientific Affairs Report 5—Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder in School Age Children
4. Council on Scientific Affairs Report 6—Calcium Supplementation, Hormone Replacement Therapy, and Osteoporosis
5. Council on Scientific Affairs Report 7—Silicone Elastomer Cerebrospinal Fluid Shunt Systems
6. Council on Scientific Affairs Report 11—"Crossover" Use of Donated Blood (in lieu of Resolution 512, I-95)
7. Council on Scientific Affairs Report 12—Alternative Medicine
8. Council on Scientific Affairs Report 13—Folk Remedies Among Ethnic Subgroups

ADOPTED AS AMENDED OR SUBSTITUTED

9. Resolution 501—Diabetes Education by Pharmacists
10. Resolution 507—Improvement in US Airlines Aircraft Emergency Kits
11. Resolution 508—Ethylene Glycol Poisoning Prevention
12. Resolution 512—Reducing Unintended Pregnancy
13. Resolution 524—Cruise Ship Medical Facilities
14. Resolution 525—Routine Screening for Iron Overload/Hemochromatosis
15. Resolution 527—Disaster Preparations
16. Board of Trustees Report 8—Calculation of Infant Mortality Rates (in lieu of Resolution 509, I-96)
17. Council on Scientific Affairs Report 3—Unlabeled Indications of Food and Drug Administration-Approved Drugs (in lieu of Resolution 508, A-96)
18. Council on Scientific Affairs Report 4—Use of Restraints for Patients in Nursing Homes (in lieu of Resolution 510, A-96)

REFERRED

19. Resolution 505—Use of the Term "Race" in a Clinical Context
20. Resolution 506—Safety in Dispensing Prescriptions
21. Resolution 509—Truth in Nutrition Labeling
22. Resolution 514—MMT in the Gasoline Supply
25. Resolution 526—Genetic Testing
26. Resolution 528—Cloning and Embryo Research

REFERRED FOR DECISION

23. Resolution 515—Revision of the National Ambient Air Quality Standards for Ozone
24. Resolution 516—Airborne Particulate Matter and Human Health
27. Resolution 519—Inclusion of Children in Research
28. Resolution 522—Patients Return to Work After Illness or Injury

NOT ADOPTED

29. Resolution 502—Antibiotic Prescribing Patterns Among Physicians and Other Practitioners
30. Resolution 503—FDA Investigation and Regulation of the Natural Food and Supplement Industry
31. Resolution 504—Restoring Pharmaceutical Stock Bottles to the Physician's Office
32. Resolution 513—AMA to Study the Wide Use of Aspirin to Prevent Infarctions
33. Resolution 517—Therapeutic Pharmaceutical vs Drug
34. Resolution 518—Discouraging the Use of Pins in the Clothing Industry
35. Resolution 520—Food Irradiation Facility
36. Resolution 529—Risks of Low-Level Radiation in Medical Diagnosis

PHYSICIAN'S RECOGNITION AWARDS

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician Recognition Award (PRA) from August 1996 through July 1997.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." In December 1992, the AMA House of Delegates revised the requirements for the PRA. Physicians now have two choices for PRA certification — the standard certificate and the PRA certificate "with Special Commendation for Self-Directed Learning." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Standard PRA Certificate. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

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Susan E. Neil, MD
Preston Nunnolley, MD
William N. Offutt, MD
Irene E. Roeckel, MD
Kooros Sajadi, MD
Glenn R. Shearer, MD
Thomas K. Slabaugh, MD

Fleming

Glenn R. Womack, MD

Floyd

Syed G. Badrudduja, MD
Nicholas R. Jurich, MD
Roger W. May, MD
Mark C. Moore, MD

Franklin

Robert A. Blair, MD
James M. Brennan, MD

Gerrard

Steven D. Green, MD

Graves

Charles E. Bea, MD
John J. Beasley, MD
Wayne E. Williams, MD

Hardin

Pedro S. Baula, MD
Victoria M. Baula, MD
Larry J. Hall, MD
Michael S. Nethers, MD
Henri C. Richard, MD
Nguyen T. Young, MD

Harrison

John G. Cooper, MD
Gerald R. Harpel, MD

Hart

Kevin L. Flowers, MD

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John A. Logan, MD
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Michael A. Tan, MD
Jonah O. Ukiwe, MD

Jefferson

Joseph C. Banis, MD
Hulburt W. Bardenwerper, MD
Atul Barry, MD
Robert F. Baxter, MD
Eric L. Berman, MD
Karen L. Bloom, MD
Anne F. Brennan, MD

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour. For the new Special Commendation Certificate, the requirements differ from the Standard Certificate in that applicants cannot include reading of medical literature as qualifying for Category 2 and applicants had to obtain a minimum of 20 credit hours of Category 1 and 20 credit hours of Category 2 annually.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

Gregory L. Brown, MD
 Ronald G. Chism, MD
 Ronald N. Collier, MD
 Mark L. Corbett, MD
 Denver B. Cornett, MD
 Mark S. Cornett, MD
 Hal M. Corwin, MD
 Arthur T. Daus, MD
 Francis Duque, MD
 John O. Faurest, MD
 Will S. Foster, MD
 S. Philip Greiver, MD
 Thomas J. Haas, MD
 Daniel L. Hafendorfer, MD
 Robert S. Howell, MD
 Tsung Y. Huang, MD
 Thomas S. Hutsell, MD
 Barbara S. Isaacs, MD
 Thomas James, MD
 Jerry L. Jamison, MD
 William N. Jennings, MD
 Karen W. Krigger, MD
 George M. Kushner, MD
 Richard L. Litt, MD
 Robert J. Middleton, MD
 Jon M. Miller, MD
 Fritz Moise, MD
 Ahmad N. Nasraty, MD
 Robert T. Noel, MD
 Vaughn W. Payne, MD
 Hugh R. Peterson, MD
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 John G. Riehm, MD
 William T. Rumage, MD
 Robert P. Schiavone, MD
 Stephen Z. Smith, MD
 John S. Spratt, MD

Lloyd R. Taustine, MD
 Frank P. Vannier, MD
 Gerald D. Verdi, MD
 William P. VonderHaar, MD
 Jeffrey A. Weiss, MD
 John J. Whitt, MD
 Robert D. Williams, MD
 Katherine A. Witherington, MD
 Thomas W. Wolff, MD

Johnson

Olen D. Amerson, MD
 Nabil Basha, MD
 Thomas A. Smith, MD

Kenton

Eugene J. Burchell, MD
 Ronald G. Fragge, MD
 Ross McHenry, MD
 John D. Morrison, MD
 Teri D. Parrott, MD
 Gregory L. Salzman, MD

Laurel

William D. Pratt, MD

Lawrence

Lee A. Balaklaw, MD
 Cesar G. Ortines, MD

Lincoln

Rodney K. Bates, MD

Madison

Glenn R. Proudfoot, MD

Mason

Robert F. Ross, MD

McCracken

Roberta L. Conrad, MD
 Keith H. Crawford, MD
 Edwin L. Grogan, MD
 Carl M. Johnson, MD
 Gerald E. Kakascik, MD
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Monroe

James E. Carter, MD

Perry

Joseph A. Florence, MD
 Irvathur N. Nayak, MD

Pike

Rao S. Bhatraju, MD
 Yasser A. Saloum, MD

Pulaski

Ramon H. Gonzalez, MD
 Patrick L. Jasper, MD
 M. Radmanesh, MD
 Betsy Reynolds, MD

Rockcastle

James A. Cunningham, MD
 George W. Griffith, MD

Russell

M. D. Phelps, MD

Warren

John S. Black, MD
 Julia C. Longo, MD
 Jerry W. Martin, MD
 Harold D. Rosdeutscher, MD

Washington

Suk-Kyung Koh, MD

Kentucky State-Wide CATO Society Meeting

One of the numerous groups that convene during our Annual KMA Meeting is the CATO Society—our Senior Physicians group. The CATO Society's primary objective is to provide an opportunity for old friends, former colleagues, and spouses to visit and share a meal together. This camaraderie always seems to be enjoyed. Ordinarily we also have a brief program in which we hope to appeal to our members' diversity of interests.

At this 1997 Annual Meeting we were apprised of the recent changes in medical education necessitated by the expanding horizons of medical science, the forces exerted by third-party payers and various social and political influences on medical care and education. This was a repeat of a similar program presented in September 1994, also by Emery A. Wilson, MD, Dean and Vice Chancellor of University of Kentucky School of Medicine, Lexington, Kentucky, and University of Louisville School of Medicine's Dean and Vice President of Hospital Affairs, Donald M. Kmetz, MD.

There were a number of changes that had taken place during the past three years, but the Deans gave us a concise view of some of the changes that had been made in response to the various forces at work in our civilization. The best news was that care of the sick and injured continues to be the focus of medical education. The subjects taught remain somewhat the same, but the teaching methods have changed markedly. Clinical courses and the patient are introduced to freshman students and much clinical teaching is in the patient's home, rural and urban clinics, as well as public and private hospitals.

Both University Medical Schools have developed fine trauma services. Research budgets have grown and the volume and quality of research in the medical and biological sciences has kept up with ever expanding horizons.

Our speakers addressed us after a generous breakfast, but their comments were of such interest that the "gray heads" resisted the urge to take a post-prandial nap!

This was a successful, informative meeting—no notes and no exams. There were 62 present, and 8 members and guests were from out in the state.

We hope that next year there may

be a greater number who join us at the CATO Society meeting just before the President's Luncheon and the installation of our next KMA President. Parking will be much easier as there is a new garage being constructed one block from the Hyatt Hotel.

Eugene H. Conner, MD
Chair, JCMS Senior
Physicians Committee



L to R: Walter S. Coe, MD; Cecil L. Grumbles, MD; Alfred T. Wagner, MD; Carl Cooper, MD; and William N. Nash, MD.



L to R: Flora Adkins; Barbara A. and James W. Davis, MD; Teresita Oropilla, MD; and John S. Sonne, MD.

Committee to Investigate Changing Trends in Medicine Report on Fraud and Abuse Laws

EDITOR'S NOTE: The KMA's Committee to Investigate Changing Trends in Medicine met during the summer and examined the issue of fraud and abuse. The committee believed the subject to be timely with the ever increasing amount of investigations and prosecutions being conducted throughout the country. It was the consensus of the committee that physicians should be educated on the various laws in this area in an effort to help them avoid problems. The following article is taken from the final report of the committee, and other articles will be published on this subject, including the article in this issue written by Martha Hasselbacher and Marc S. Murphy.

There is a widely held belief throughout the United States that money lost in the health care system through fraud and abuse constitutes a significant amount of the money spent, especially in Medicare. This belief has led to a wide array of legislation throughout the country in an effort to crack down on alleged fraud and abuse. The system that has been created to conduct these investigations, however, is a self-perpetuating system. The government is able to use the money it receives from settling these cases to conduct other such investigations. Recent estimates have calculated that for every dollar spent on investigating health care fraud and abuse, the federal government receives \$23 in settlements.¹

The KMA's Committee to Investigate Changing Trends in Medicine recently met to discuss fraud and abuse laws and their effect on physicians. The committee received information and presentations on these laws from Martha

Hasselbacher, an attorney with the law firm of Stites & Harbison in Louisville, and Patrick Padgett, Director of Socio-economic Affairs and Staff Counsel for the KMA. Their presentations elicited a tremendous amount of discussion among the committee members, all of whom expressed deep concern about today's climate regarding fraud and abuse.

The federal government has a wide array of laws to use against physicians. The federal Anti-Kickback statute prohibits physicians from receiving anything of value in exchange for a referral to another organization.² Traditional relationships and practices in the health care arena should be reconsidered by physicians. Discounts, joint ventures, and physician recruitment incentives could, in some forms, be considered violations of this law.

Congress has also passed what has become commonly known as the "Stark Laws." These laws create express prohibitions between certain physician-provider relationships without regard to whether the parties intend to induce referrals. The existence of a financial relationship between a physician and another provider can be triggered if the relationship involves ownership, investment, debt, or compensation arrangements between the parties. Services covered under this law include: clinical laboratory services, physician therapy services, occupational therapy services, radiology services, radiation therapy services, durable medical equipment, home health services, outpatient prescription drugs, and inpatient/outpatient hospital services. The prohibition against any type of investment also extends to a physician's family.³

The federal government is also using other statutes to prosecute physicians. Some physicians have been prosecuted under the federal Mail Fraud and Wire Fraud statutes for waiving co-payments.^{4,5} One reason Medicare claims are frequently prosecuted under the Mail Fraud statute is that it allows for the seizure of the physician's assets. Such laws have also been used when it is suspected that services have been provided that the federal government believes are not necessary. This is especially troubling because the government, by taking such action, is second guessing physicians in their direct treatment of patients.

Many providers are also being prosecuted under the Racketeer Influenced and Corrupt Organization's Act, also known as "RICO," which prohibits anyone from receiving income from actions that constitute a pattern of "racketeering activity."⁶ This statute is most commonly used against organized crime, which shows the level federal investigators are willing to go to obtain convictions against health care providers.

There have been many cases against physicians involving the Federal False Claims Act, which was passed during the Civil War to prevent manufacturers of military equipment from producing and providing shoddy products to the government.⁷ In essence, a prosecution under this law is based on someone claiming money from the government and using false statements in order to obtain that money. This law is being used by law enforcement against physicians because of the potential for false claims being submitted by physician offices in the Medicaid and Medicare systems. Physicians should be careful to educate themselves and their

office staff on proper procedures for filing claims because they can be held liable for violations of the law.

The False Claims Act also allows for *qui tam* actions, which permits a private citizen to sue a health care entity on behalf of the government. The Department of Justice receives these suits under seal and decides whether to participate in the suit. Many citizens are filing these suits because they can get anywhere from 10% to 25% of a civil money settlement. These types of actions open up the prospect of physicians being sued by competitors or disgruntled employees and may affect the traditional physician/patient relationship.

Last year, in an effort to expand health care fraud and abuse laws, Congress passed the Health Insurance Portability and Accountability Act, commonly referred to as "HIPAA" or "Kennedy/Kassebaum." This law expanded many current health care fraud laws to apply to not only the Medicaid and Medicare systems, but also to *any* health benefit plan, including private insurance plans.⁸ A discussion of this law and how it applies to physicians can be found in the July 1997 issue of the *Journal of the Kentucky Medical Association*.

Statistics regarding health care investigations are eye opening. The FBI Fraud Unit conducted 365 such investigations in 1991, while in 1996, prior to the enactment of HIPAA, 2,000 investigations were conducted by the unit. Since the enactment of HIPAA, the Department for Health and Human Services Office of the Inspector General has closed nearly \$1 billion in settlements. Two investigations of teaching hospitals earlier in the year netted the government nearly \$42 million in settlements.⁹

While there are many investigations being conducted under current law,

there has been an effort to pass even broader health care fraud and abuse laws. President Clinton proposed such a law earlier in the year. While the President's bill was defeated, another bill recently passed by Congress fines any provider who "knew or should have known" that they were contracting with another health care provider who had been excluded from the Medicare and Medicaid systems. Such a bill is alarming because it is difficult to determine if a certain entity has been excluded from those programs.

The amount of money collected from fraud cases will lead to more investigations by the government. The trend seems to be for the government to prosecute under the False Claims Act because it has not had much success prosecuting the Anti-Kickback cases. There is also a move afoot to penalize providers for cutting back on the amount of care given to a patient in order to receive a financial incentive, as well as a trend to allow private lawsuits by citizens against managed care entities for not providing enough care.

The war on drugs seems to be dead and the new target by the government appears to be health care. Such entities as the National Health Care Anti-Fraud Association and the National Council Against Health Fraud have been formed in response to this new national priority. Physicians should be familiar with the laws in this area and educate their office staff on the proper procedures to avoid any problems. Physicians should also seek the advice of an attorney if potential issues come up in their practices.

Physicians could hire someone to review the procedures in their practices to determine whether they are in compliance with fraud and abuse laws. When a review of office procedures is considered, physicians should also look

into the need for "corporate compliance plans." These plans are formulated by consultants and attorneys for use by various health care entities to assist in complying with the numerous fraud and abuse laws. In many cases, if the provider can prove to the government that everything possible was done to comply with the law, including implementing a corporate compliance plan, the fines for violations can be lower.

All is not gloom and doom. Among academic circles, there seems to be a movement to restrict the use of fraud and abuse laws because they pose barriers to providers integrating and holding down the costs of medical care in the private sector. There also seems to be concern that more attention is being focused on finding those who have already committed violations as opposed to implementing procedures to prevent violations. This trend, hopefully, will lead to a rational evaluation of fraud and abuse laws to determine their effect on the ability of physicians to provide adequate care to their patients at the lowest possible cost.

Marjorie R. Fitzgerald, MD, is the Chair of the Committee to Investigate Changing Trends in Medicine.

References

1. Johnson J. Feds intensify fraud scrutiny, hone tactics. *American Medical News*, June 9, 1997;7.
2. 42 U.S.C. § 1320a-7b(b)
3. 42 U.S.C. § 1395nn
4. 18 U.S.C. § 1341
5. 18 U.S.C. § 1343
6. 18 U.S.C. § 1961 *et seq.*
7. 31 U.S.C. § 3729
8. Public Law 104-191
9. Johnson J. Are you guilty until proven innocent? *American Medical News*, June 9, 1997;1,7,8.

PEOPLE

Angela Crone, MD, has received the fifth annual Carroll Witten Award of the Jefferson County Chapter of the American Academy of Family Physicians.

Nancy Swikert, MD, represented the Kentucky Chapter of the AAFP when she accepted a Membership Award during the AAFP's Annual Leadership Conference earlier this year. The certificate reads "The (AAFP) Commission on Membership and Membership Services proudly recognizes the Kentucky Chapter for outstanding achievement in the area of membership development through enrollment of 100% of its Family Practice Residents as Academy Members, 1996."

UPDATES

Health Kentucky, Inc Awards

Health Kentucky, Inc has recognized three individuals, one clinic, and one pharmacy for their generosity in volunteer work. Health Kentucky is a non-profit, educational, charitable organization that was formed initially by KMA and other groups to provide physician, hospital, and pharmaceutical services to indigent patients. The recipients of the awards are: **John Asriel, MD**, the 1997 Kentucky Physicians Care Award; **Gregory R. Baker, Jr, DMD**, the 1997 Kentucky Dentist Care Award; **Mr Robert Johnson**, the 1997 Service to Humanity Award; **University of Kentucky Medical Center Family Practice Clinic**, the 1997 Kentucky Physicians Care Award; and **Kroger Pharmacy**, the 1997 Kentucky Pharmacy Providers Award.

U of L Reports That All Eye Surgery Equipment May Not be Created Equal

Nearsighted people who hate glasses can choose from two currently approved surgical options—radial keratotomy and excimer laser surgery—with more procedures on the way. U of L ophthalmology professor **George John, MD**, however, cautions the visually challenged to beware of the "black box."

Excimer surgery uses a computer-assisted laser system that corrects the curvature of nearsighted eyes by vaporizing tiny layers of surface eye tissue. However, lasers in some other countries aren't as closely regulated as in the United States. A black box is a laser system that hasn't received FDA approval.

Although the lasers may be billed as "just like" or "as good as" the two FDA-approved devices, Summit and VISX, Dr John warns that these are cases in which what you don't know can hurt you.

Celebrating Anniversaries

Recently celebrating a 25th Anniversary in the University of Louisville School of Medicine were **Sofia Franco, MD**, pediatrics-children-youth, and **Leonard Weiner, MD**, surgery.

EarCheck™ Middle Ear Monitor Receives FDA 510K Clearance

MDI Instruments, Inc has announced that it has received FDA 510K clearance to market the EarCheck™ Middle Ear Monitor to consumers. The new instrument is based on the EarCheck PRO™ Otitis Media Detector, a device for physicians which was introduced in May 1997 to aid in the accurate diagnosis of otitis media. According to MDI, the EarCheck™ monitor is the first in-home device that enables parents to monitor their chil-

dren for middle ear fluid, frequently associated with otitis media.

MDI reports that the EarCheck™ monitor determines the presence of fluid in the middle ear by using sonar, or acoustic reflectometry, technology to measure the response of the eardrum to gentle sound waves. The EarCheck PRO™ Otitis Media Detector, on which the new consumer instrument is based, is a device for physicians that is comparable in accuracy to a tympanometer, but painless for the child because it does not require pressurization of the child's ear canal, according to MDI's report.

The Monitor will be available to consumers in the fall of 1997.

U of L Restructures Training in Family Medicine

Recently honored by the Society of Teachers of Family Medicine (STFM) as one of the top innovative programs in the country, the U of L Department of Family and Community Medicine has developed "cutting-edge" approaches to preparing young doctors. The department trains residents in managed-care facilities and uses the latest computer-instruction technologies to incorporate current research into the patient care provided by its residents.

Under the direction of Chairman **Richard D. Clover, MD**, and Residency Director **Richard D. Blondell, MD**, the department prepares students for success in the rapidly changing world of medical care. According to the U of L report, problems that plagued the program a few years ago—resident attrition, financial straits, limited training sites, for example—are a thing of the past. The most pressing problem now, according to Blondell, is getting the word out to other departments and medical students at U of L. "We now have a nationally competitive training program."

New resident training sites serve patients in urban and suburban

Louisville. Blondell has supervised the creation of unique, mutually beneficial partnerships with private health care providers to train residents in realistic office sites. Residents learn about managed care working with Humana Health Care Plans, Inc at the Family Medicine Center/Newburg. The practice management division of Jewish Hospital HealthCare Services is a valuable partner in training residents in a private practice setting at the Iroquois Medical Center, and the University Ambulatory Care Center serves local patients who are un- or under-insured, says the report.

"With these three training sites," Blondell said, "we can provide health care to a diversified population base and give residents some choices in the type of preparation they receive."

As a specialty, family practice is a mere 30 years old. The family medicine department of U of L, founded 25 years ago, started with two faculty members and one resident. The department currently has 25 residents, 18 faculty members and one registered dietitian. More than 200 professionals, mostly private practitioners, donate their time to help train residents, contributing immeasurably to the teaching mission of the department.

In 1992, the department's mission broadened when the departments of family medicine and community medicine combined and established four programs: family medicine, community medicine, geriatrics and humanism (the holistic treatment of patients, not diseases).

Over the door of residency offices in the Rudd Heart and Lung Center hangs a sign that reads "Clinical Center of Excellence for Family and Community Medicine." The goal, said Blondell, "is to constantly strive toward excellence in training. The family practice resident at U of L has varied and superior training options. We want to continue to be innovative in the training of residents."

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

Mohammad A Hossain MD — EM
202 George Ann Dr, Middlesboro
40965-2622
1976, Dacca, Bangladesh

Boyle

Selcuk A Tombul DO — C
PO Box 88, Danville 40423-0088
1991, New York College

Clark

Liset N Stoletniy MD — IM
RR 5 Box 555, Manchester 40962
1985, Montevideo, Uruguay

Fayette

Charlie Asher Becknell MD — D
833 Palomino Ln, Lexington 40503
1980, U of Kentucky

Jolinda R Dillow MD — D
1401 Harrodsburg Rd Ste C415,
Lexington 40504
1992, U of Kentucky

Paolo Fanti MD — NEP
UKMC MN-564, Lexington 40536
1979, U of Bologna

Lawrence K Gates Jr MD —GE
100 Cassidy Ave, Lexington 40502-2302
1986, Duke

John C Gurley MD — C
2157 Sallee Dr, Lexington 40513
1980, Ohio State, Columbus

Alastair A Hutchison MD — PD
2900 Candlelight Way Apt A, Lexington
40502-2826
1971, U of Aberdeen, Scotland

Robert C Johnson Jr MD — S
3673 Gladman Way, Lexington 40503-3715
1989, Med Col of Virginia

Cheryl Koch MD — FP
1225 Crenshaw Ln, Nicholasville 40356
1995, U of Kentucky

Fabio M Leonelli MD — C
137 Tahoma Rd, Lexington 40503-2018
1977, U of Perugia, Italy

Craig J McClain MD — GE
170 Cherokee Park, Lexington 40503
1972, U of Tennessee

Amitkumar N Mehta MD — AN
413 Shoreside Dr, Lexington 40515-5699
1980, SMT, NHL, India

Nicholas J Nickl III MD — GE
400 Dudley Rd, Lexington 40502
1982, U of Tennessee

Daryl L Pauly MD — EM
928 Chinoe Rd, Lexington 40502
1982, U of Kentucky

Cecil E Peppiatt III MD — IM
1374 Fontaine Rd, Lexington 40502
1994, Med Col of Georgia

Gordon L Phillips MD — IM
2112 Island Point, Lexington 40502
1971, U of Oklahoma

Sanjeev Rastogi MD — NEP
2404 Abbeywood Rd, Lexington 40515-
1261

1983, Guy's Hospital, England
William Robert Revelette MD — PD
3513 McNair Way, Lexington 40513

1994, U of Kentucky
Paul Joseph Rychwalski MD — OPH
175 N Mt Tabor Apt 104, Lexington
40502

1993, Med Col of Wisconsin
Steven I Shedlofsky MD — GE
2105 Broadhead Pl, Lexington 40515

1974, U of Michigan
Stanley W Sizemore MD — FP
106 Peachtree St, Nicholasville 40356

1988, U of Kentucky
Patricia D Thompson MD — IM
4192 Heartwood Dr, Lexington 40515

1990, Wright State
Margaret K Winkler MD — PD
214 Lackawanna, Lexington 40503-7916
1991, U of S Carolina

Franklin

Jennie C Mangun MD — PD
1071 Bittersweet Ln, Frankfort 40601-
7604

1993, U of Louisville

Hopkins

Greg Lawler MD — R
200 Clinic Dr, Madisonville 42431
1991, New York Med Col

Jerry R McNeal MD — PD
200 Clinic Dr, Madisonville 42431
1968, U of Kansas

Phatama Padavanija MD — HEM

200 Clinic Dr, Madisonville 42431

1990, U of S Alabama

Ralph Wayne Templin MD — R

200 Clinic Dr, Madisonville 42431

1987, Texas Col of Osteopathic Med

Jefferson**James G Adams MD — AN**

7607 Deer Meadow Dr, Louisville 40241

1991, U of Louisville

Lawrence S Amesse MD — OBG

2400 Mellwood Ave Apt 907, Louisville 40206

1985, Quillen-Dishner

Miren Asumendi DO — P

1764 Spring Dr, Louisville 40205

1989, Col of Osteopathic Med, Iowa

L Barrett Bernard MD — EM

6 Anchorage Pointe, Anchorage 40223

1977, U of Louisville

Brent R Ellmers MD — S

11109 Oakhurst Rd, Louisville 40245

1990, Indiana U

Syed Q Kazmi MD — IM

1 Riverpointe Plz Apt 817, Jeffersonville 47130-3212

1983, Dow, Pakistan

Muhlenberg**Eric Bandy MD — IM**

211 S Cherry St, Greenville 42345

1995, U of Kentucky

Taylor**James E Ewing MD — OTO**

105 Greenbriar Dr Ste A,

Campbellsville 42718

1992, U of Kentucky

In-Training**Fayette****Maria A Pavez MD — N****DEATHS****Robert M. Sirkle, MD****Lexington****1910-1997**

Robert M. Sirkle, MD, a retired family practitioner, died June 19, 1997. A 1939 graduate of the University of Cincinnati College of Medicine, Dr Sirkle was a life member of KMA.

Louis E. Aaron, MD**Columbia****1916-1997**

Louis E. Aaron, MD, a retired general surgeon, died August 13, 1997. Dr Aaron was a 1943 graduate of the University of Louisville School of Medicine and a life member of KMA.

Donald S. Park, MD**Hagerhill****1921-1997**

Donald S. Park, MD, a pediatrician, died August 19, 1997. A 1948 graduate of Seoul National University, Korea, Dr Park was an active member of KMA.

Charles L. Roser, MD**Louisville****1906-1997**

Charles L. Roser, MD, a retired otolaryngologist, died September 2, 1997. Dr Roser was a 1931 graduate of the University of Louisville School of Medicine and a life member of KMA.

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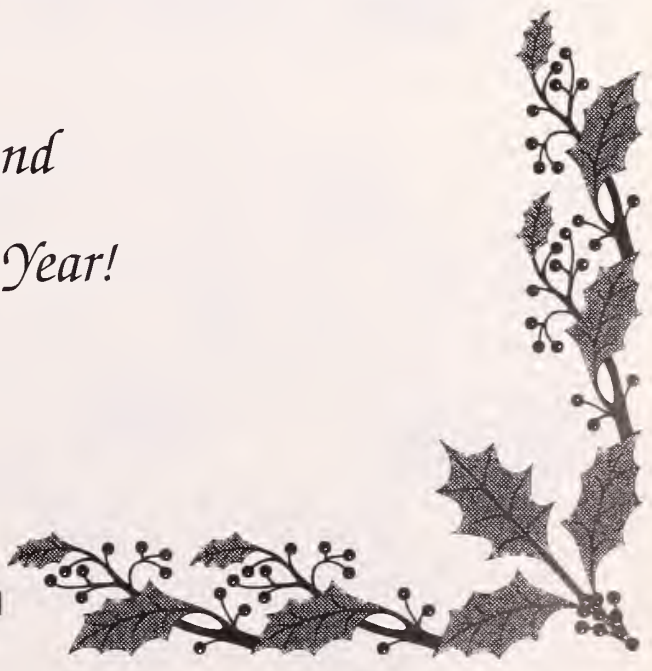


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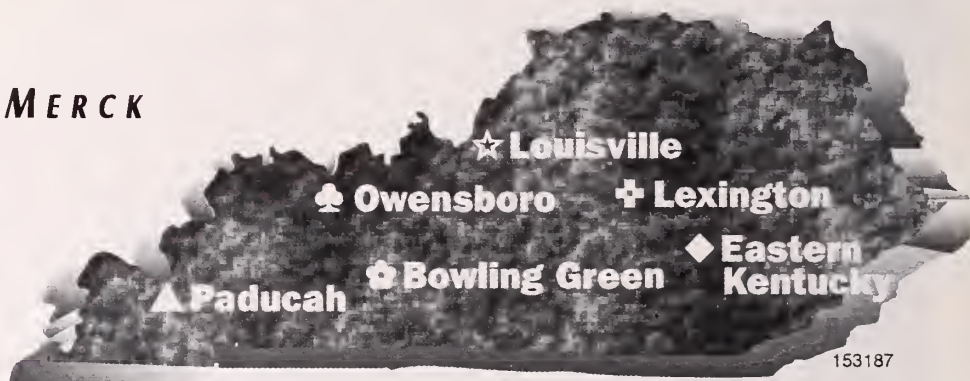


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JOURNAL OF THE
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VOLUME 95, NUMBER 12

DECEMBER 1997

SPECIAL ARTICLE	The Kentucky Emergency Medical Services Information System: Current Progress and Future Goals <i>James E. Svenson, MD; Carl W. Spurlock, PhD; Robert Calhoun, MPH</i>	509
EDITORIAL	Consumerism <i>A. Evan Overstreet, MD, Editor</i>	515
SPECIAL FEATURES	Delegate Roll Call — 1997 House of Delegates Digest of Proceedings — 1997 House of Delegates Index to Proceedings and Reports Index to Resolutions Index to <i>Journal</i> Volume 95 — 1997 KEMPAC Banquet KMA 1997-98 Organization Chart KMA Reference Committees	532 535 536 537 586 528 585 538
ASSOCIATION	<i>Monitoring Medicine</i> 147th KMA Annual Meeting In Memoriam 1997-98 Committees	505 518 507 582
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Classified Information for Authors	503 590 517 589 513



COVER:
This issue of the Journal provides extensive coverage of the 147th KMA Annual Meeting, which was held in Louisville on September 15-17, 1997. An overview begins on page 518, with House of Delegates coverage beginning on page 539.

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Strategic Planning for the Future

It is a well-known axiom that strategic planning is a road map to the future. Many of the disciplines in which we participate may have such a map; others have no map at all! Perhaps the need for the right map can best be demonstrated by one of my favorite stories about a doctor-patient relationship.

The patient said to his physician, "I want to lose weight."

The doctor responded with the following recommendation. "Here is a copy of a good diet; in addition to following this diet I want you to walk 5 miles a day for 300 days; then call me back with a report on how you are doing."

Three hundred days later, the patient called and gave the doctor the following report. "You were right, doctor. I've lost the weight I wanted to and I feel fine, but I have just one problem. I'm 1500 miles from home!"

This simple bit of humor offers a prime example of what happens when one has the wrong road map; it may well send one off on the wrong journey.

As the Kentucky Medical Association approaches the end of this century and begins planning for the new millennium, we must review the maps of our past and develop a new road map that will prepare us for the 21st century.

For example, the question may be asked, "Had we had a strategic plan 10 years ago, could it have made any difference?" I personally believe that if we had developed a strategic planning process in the late 1980s or early 90s, we would have dealt with the need for a statewide PPO and would have been ahead of the game by at least 5 years.

We must not dwell on the past,

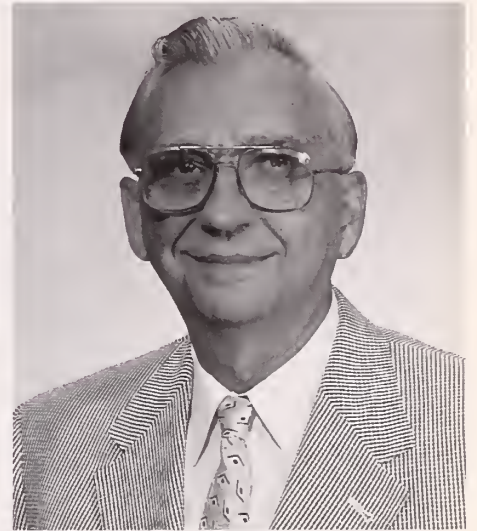
however, but invest our energy in developing a helpful "road map" into the future.

We will have a more secure and productive future in our Association if we involve more of our members in the planning process. Implementation of such a process will allow input and ideas from many of us by utilizing Internet, e-mail, focus groups, and one-

"We will have a more secure and productive future in our Association if we involve more of our members in the planning process."

on-one interviews. There is no substitute for information that is broad-based. Such information will enable your KMA leadership and staff to develop a consensus about our direction, identify our parameters and set reasonable goals for 1-3 years duration with an annual monitoring process to see how well we are doing.

We will anticipate staff having the outline of a planning process and a facilitator to present to the Board in our December '97 meeting. The success of such a process will be enhanced by the use of a trained professional as our facilitator. Such a person will bring real objectivity to the process. We will need to have proposed budget in place to be



C. Kenneth Peters, MD

presented in March 1998 to the Budget Committee. Strategic planning is not a stop-gap affair, but an ongoing process of review. Dr Stephens, our President-Elect, is very supportive of this process, because it will carry over into 1999 and his tenure as our president.

It is a foregone conclusion that some changes may come from a serious planning process. We must remind ourselves that change for the sake of change serves no purpose, but change for the sake of the future will serve us well.

C. Kenneth Peters, MD
KMA President

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NEWS FOR KENTUCKY PHYSICIANS

STATE LEGISLATIVE REPORT

Wally O. Montgomery, MD, Chair

The Kentucky General Assembly is expected to consider approximately 150 legislative medical/health initiatives during its 60 day session. Several issues of considerable interest to physicians will be considered. We urge you to begin contacting your State Representative and Senator concerning these and other issues.

Patient Protection

During the Special Session, the primary focus of KMA was the Patient Protection Provisions embodied in both Senate Bill 1 and House Bill 3. The Senate and House refused to compromise over the issue of "pay or play" vs the High Risk Pool issue, thus KMA's Patient Protection Provisions were lost. During the 1998 Regular Session, KMA will propose a strengthened and updated version of Patient Protection Provisions. New provisions expected to be included in a package to resolve the insurance crisis include a "point of service" option, along with requirements that managed care officials confirm "rejections" or "denials" in writing when they decline treating physician recommendations.

Defining Physician Offices

KMA members should be aware of continuing efforts by Cabinet for Health Services officials to "define" physician offices. Since the advent of Certificate of Need (CON) in 1972, physician offices have been excluded. Presently, offices and clinics are excluded from the CON process unless they purchase equipment exceeding \$1.5 Million. The 1994 Kentucky General Assembly increased the physician office threshold from \$500,000 to \$1 Million and in 1996 the KGA upped the threshold once again to \$1.5 Million. KMA opposes any effort, either by legislation or regulation, to define physician offices.

Health Departments

Several legislators support legislation permitting

Health Departments to directly compete with physician offices for private patients. While some Health Departments are considering this concept, interest in expanding office hours, providing patients with "on call" services at nights, weekends, and holidays, and willingness to accept lower Medicaid reimbursement has not been evident. Sources at the Cabinet for Human Services and members of Kentucky General Assembly indicate that this is not an "administrative" or "legislative" leadership proposal.

Alternative Medicine

During the 1996 Kentucky General Assembly a radical legislative proposal was introduced to prevent, or sharply reduce the Kentucky Board of Medical Licensure's ability to function and exercise its powers. Some proponents of "alternative or conventional medicine" are recommending that the legislation be introduced again in 1998. This proposal, which is fairly well financed and lobbied extensively during the interim, should be taken seriously. Contact your elected Representatives and discuss the ramifications of such legislation. The 1996 proposal included the following:

- (1) "Nothing in KRS 311.530 to 311.620 shall be construed to prevent a physician's use of whatever medical care, conventional or nonconventional, for which a physician has a reasonable expectation of efficacy in the treatment of human conditions, ailments, diseases, injuries, or infirmities."
- (2) "Nonconventional medical treatments" means medical treatments of any and all means for which a physician has a reasonable expectation of efficacy but which have not yet gained general acceptance within the United States."
- (3) "In the case of a grievance involving issues of clinical practice, experts shall be consulted. In the case of a grievance



involving nonconventional medical treatments, experts who dedicate a significant portion of their practice to the use of these treatments shall be consulted."

(4) The section relating to "bringing the medical profession into disreputable," "standards of acceptable and prevailing medical practice," and

"conforming to principles of medical ethics" was stricken. If you have questions regarding these or other issues contact KMA Headquarters.

NATIONAL LEGISLATIVE REPORT

Donald C. Barton, MD, Chair

The following is a brief overview of provisions in the "Balanced Budget Act of 1997." Of particular concern are provisions relating to Medicare and physician reimbursement. According to reports, "balanced budget" savings came primarily from Medicare cuts. Physician reimbursement was the target for approximately 10% or \$5.3 billion of the recommended reductions.

PHYSICIANS SERVICES

- Establishes a single conversion factor for 1998
- Establishes update to conversion factor to match spending under sustainable growth rate
- Replacement of Volume performance Standard with sustainable growth rate
- Payment rules for anesthesia services altered
- Implements Resourced-based physician practice expense
One year implementation delay
Phased in implementation
HCFA Secretary directed to develop new RBRVUs
Comptroller General of GAO required to review and evaluate HCFA rules
Malpractice Relative value units altered in year 2000
- Facilitates the use of private contracts under the Medicare program

Medicare provisions relating to physicians and their offices

- Direct payment to PAs and ARNPs. The "incident to" provision which required physician supervision or collaboration was repealed.
- A "three strikes you're out" provision was enacted under the fraud and abuse statutes which allow the federal government to permanently remove a provider from Medicare if three convictions of fraud or abuse occurs.
- A 1-800 reporting line for patients and others who want to report suspected abuse has been funded.
- Physicians required to supply diagnostic information when ordering x-rays, laboratory tests, DME, prosthesis, etc.
- Social Security numbers required for specified services.
- Advanced Directives required in medical records.
- Home Health transferred from Part A to Part B.
- "Normative" guidelines for services will be established, and physicians notified if they "exceed the norm."
- Eliminates the x-ray requirement for chiropractic manual manipulation of the spine.

Patient preventive initiatives

- Mammography screening
- Breast exam/pap smear/pelvic exam every 3 years

- Prostate screening
- Colorectal screening
- Diabetes screening and training
- Bone mass measurement for high risk patients
- Vaccine outreach

Medicare to offer several insurance choices to recipients including:

- Fee for Service.
- Medicare+Choice which may include HMO, PPO, PSO, MSA. Crossovers (Medicare/Medicaid) patients are ineligible for the "choice" provisions. There can be no restrictions on patients during the "election period," and termination can only occur for non payment, disruptive behavior, or the insurer leaves the market.
- Patient Protection Provisions added to Medicare/Medicaid.

The AMA priorities during the balance of the Session:

- CLIA Reform
- Repeal of dual eligible provision
- Freedom to contract with Medicare patients (KYL Amendment)
- Anti-gag legislation (Ganske Legislation)
- Liability reform (\$250,000 Cap)
- Changes to the tobacco settlement agreement.

In Memoriam

The end of a man's life is often compared to the well-written play, where the principal persons still act in character, whatever the fate is which they undergo.

— Joseph Addison
The Spectator

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The Kentucky Emergency Medical Services Information System: Current Progress and Future Goals

James E. Svenson, MD; Carl W. Spurlock, PhD; Robert Calhoun, MPH

The Kentucky Emergency Medical Services Information System was formed in 1993 to establish a centralized registry of prehospital and emergency department data. These data can aid individual providers in planning and providing patient services and state planners in systems development and disease surveillance. This article seeks to provide an overview of the system for providers of acute care services in Kentucky, its current capabilities and future goals.

Since 1993, the Kentucky Department for Public Health has initiated and funded a project for a central registry of prehospital and hospital-based data. With this goal in mind, the Kentucky Emergency Medical Services Information Systems (KEMSIS) was formed as part of the Kentucky Injury Prevention and Research Center. With the addition of a block of federal funding, in 1995 KEMSIS purchased the software license for the establishment of a prehospital and emergency department database. KEMSIS has offered, and continues to offer, this software at no cost to all prehospital and emergency department providers in Kentucky. The purpose of this article is to give an overview of the progress that has been made by KEMSIS and to discuss future goals and directions.

Overview

Kentucky has a population of approximately 3,685,000 (1990 census). Twenty-eight percent of the population is less than 18 years of age. Eighty-nine percent of the population is white, while 10% is black. There are 120 counties. The counties have been organized into 15 Area Development Districts (ADD) to facilitate economic development and the delivery of human services. Twenty-six counties have a population of less than 10,000. There are 49 counties which comprise the Appalachian region in Kentucky.

For our purposes, we have defined an urban county as one with a population density of over 150 people/sq mile or one with an urban population of greater than 15,000 with over 50% of the county population living in the urban area. This is slightly different than previous definitions in which we used designations by the Office of Management and Budget and reflect areas with more centralized populations. As such, there are 19 counties in Kentucky that are urban. Fifty-two percent of the population live in these urban counties.

During 1995, there were 267 licensed ambulance services in Kentucky. Nine of these services are actually situated in adjoining states, three are neonatal transports only, and five are air ambulances. These are not included in this report. Thus, there are 250 services which are licensed ground services in Kentucky. Of these, 97 are ALS services distributed in 73 counties (Fig 1). Thirty-one percent of the population have ALS service available by all prehospital services within the county (50 counties). In all, 81% of the population has some ALS service available to them in the county, while 19% have only BLS services.

Fram the Department of Emergency Medicine, University of Kentucky, Lexington, KY (Dr Svenson); Kentucky Injury Prevention and Research Center, Lexington, KY (Drs Svenson and Spurlock); and the Emergency Medical Services Branch, Department for Health Services, Frankfort, KY (Dr Calhoun).

Key
 Rural-BLS
 Rural-ALS
 Urban-BLS
 Urban-ALS



Fig 1 — Distribution of EMS services in Kentucky

Kentucky EMS Information System

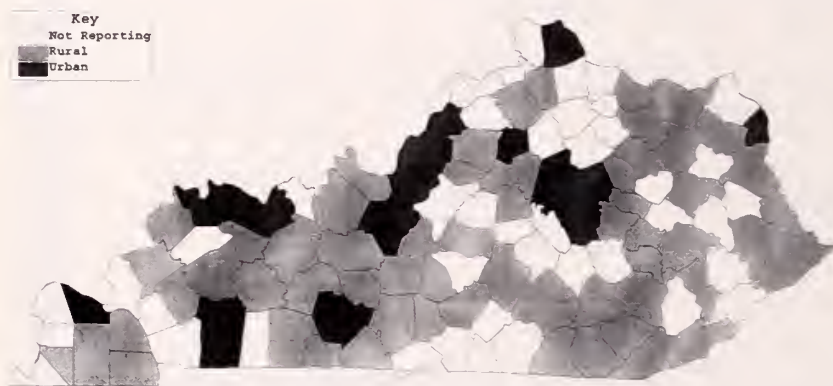


Fig 2 — Distribution of counties with EMS reporting to KEMSIS



Fig 3 — Distribution of counties with population-based EMS reporting



Fig 4 — Distribution of hospitals with 24-hour emergency departments in Kentucky

Ninety-one services are currently submitting computerized reports to KEMSIS, from 77 counties (Fig 2). Of these, all services within the county are reporting in 52. For those 52, true population-based data on EMS usage is available (Fig 3). In 40

of the counties with population-based data, ALS care is available to the population. Thirty-nine of these 40 counties have all services within the county as ALS services. Eighty-five percent of the reporting population have some ALS service available to them (for 76% the entire county has ALS services). Six counties are urban counties, while the other 46 are rural.

In Kentucky there are 108 hospitals with emergency departments (ED) open 24 hours per day (Fig 4). Of these, two have been verified as level 1 trauma centers by the American College of Surgeons (ACS): University of Louisville Hospital and the University of Kentucky Hospital. There has been no formal categorization of emergency facilities in Kentucky either by the ACS or by the state. A separate attempt at classification of hospitals according to availability of ED services utilizing subjective reports of capabilities has been done.¹⁸ There are 35 counties in which no acute care hospital is located. Thirteen of these counties are in Appalachia. There is no difference in the relative distribution of hospitals and the level of care available between the Appalachian and non-Appalachian regions of Kentucky.

There are several existing patterns for referral of patients within Kentucky. Hospitals which report formal referral agreements or customary non-formalized practice usually refer to level 1 or level 2 centers. A few hospitals refer patients to level 3 centers. In no instance, when transfer conventions are reported, are patients transferred laterally to a hospital with the same designation. Border counties refer to level 1 centers in Cincinnati, Huntington, Knoxville, and Nashville.

The initial goal of KEMSIS was to try to have the (or one of the) largest hospitals in each ADD reporting to the ED database. There are, presently, eight hospitals that have had the ED software installed and seven more committed to the installation (Fig 5). Data is being submitted from four of the hospitals to KEMSIS. At least one hospital in every ADD has been approached to participate in the database, but as yet, only 12 of the 15 ADDs have a hospital committed or reporting.

Data

The data elements which are presently included in the prehospital reporting to KEMSIS are a subset of the elements in the state's standardized run sheet.

For 1995, there were 194,406 runs reported from the 91 services reporting computerized data.

Of these, 107,439 (55%) of the runs were designated as emergency runs. The other 45% were scheduled interfacility transfers and as such not considered emergency runs. Of the emergency runs, 47,538 (44%) were in counties which have population-based reporting. Overall, ALS care was available in 84,922 (79%) of the runs; 35,429 (75%) of the runs in population-based counties. Forty-five percent (46,036) of runs were reported from rural counties; 69% (33,099) of the population-based counties. ALS care was available for 98% of runs from urban areas and 61% of the runs from rural areas (100% and 63% of the runs for population-based counties respectively). Twenty-six percent (27,790) of the runs were for trauma.

The data elements which are included in the emergency department register are generally collected by hospitals under uniform billing. Some additional data elements are collected by some hospitals, but not by others. Hospitals are only asked to report data that they have available; additional data collection and entry is not required or expected.

For 1995, there was incomplete data available from three hospitals. There were 60,243 visits reported from the three hospitals: 20,130 (33%) were in patients less than 20 years of age, 32,843 (54%) were for patients 20 to 65 years of age, and 7,260 (13%) were in elderly patients (greater than 65 years of age). Sixteen percent of patients were treated during the night hours (11PM to 7AM), 34% during the day (7AM to 3PM), and 48% during the evening hours (3PM to 11PM). Thirty-nine percent of patients had an ED stay of less than 2 hours, while 26% stayed between 2 and 4 hours, and 24% had ED stays of greater than 4 hours.

Goals and Directions

Kentucky has a unique opportunity to become a leader in the establishment of a statewide database incorporating prehospital and hospital-based data elements. At the central level, these data have numerous potential uses. They can be used for EMS and trauma systems outcomes evaluation.^{5,6,17} In 1994, the Department for Health Services received a grant from the Department of Health and Human Services (DHHS) Division of Trauma and Emergency Medical Systems to initiate trauma systems planning. Under this grant, a trauma systems plan was developed and published.¹⁹ This plan has been recommended by the Kentucky EMS Council for adoption by the Cabinet for Health Services. KEMSIS data can be used in

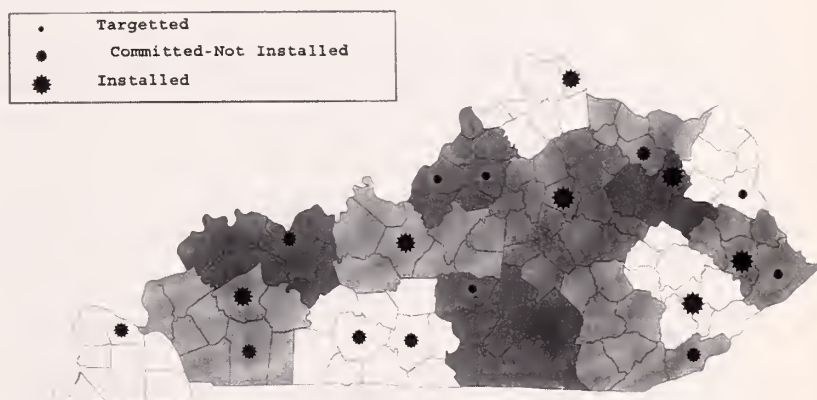


Fig 5 — Hospitals targeted and reporting to KEMSIS (by ADD)

assessing the effectiveness of this plan. Similarly, data can be utilized to evaluate the effectiveness of prehospital and emergency departments in dealing with other medical emergencies, such as acute myocardial infarction. Data can also be used to assess the factors associated with regional differences in the delivery of medical care.^{3,4}

KEMSIS data at the central level can also be used for public health injury morbidity surveillance.^{11, 13, 15, 16} The master registry can be used to create additional, special purpose injury registries (eg, spinal cord and head injury registry). With the incorporation of police data on motor vehicle accidents or crimes in which weapons were used, registries of firearms injuries, eg, could be established.¹⁴

Finally, at the central level, data can be used for population-based prehospital and emergency department research.⁷ Researchers from around the state with specific questions can access data in the central registry that will help answer them.

One of the problems confronting KEMSIS is the linkage of non-nominal data in the prehospital and ED data. Using probabilistic data linking, we have to date been able to link approximately 85% of prehospital and hospital records of motor vehicle crash victims. The linkage of prehospital and emergency department data can be used in the evaluation of morbidity and economic impact of specific injuries, or the impact of certain therapies.^{10, 12} Previous research has shown an association between ALS care and lower traumatic injury death rates, but using linked data we have the opportunity to directly test the association.^{9, 20}

Kentucky EMS Information System

While the state has an interest in establishing a centralized data registry, individual providers must also have some positive rewards if they are to participate in a voluntary system. For prehospital providers, the computerization of services can lead to more efficient billing, easier analysis of frequency-of-use data, and facilitate quality assurance activities. Preprogrammed reports for each of the above are included in the software provided by KEMSIS. Since reporting of data to the state EMS branch is mandatory, this increase in efficiency should spur the further computerization of the state's EMS services. Although there is an expense in purchase of equipment to the individual providers, the availability of free software and state matching grants for hardware drastically lowers this outlay. We hope that even small providers will look closely at the rewards to be gained for a small investment.

For individual emergency departments, there are also rewards for reporting to KEMSIS. The software and installation is free. For hospitals with computerized registration and billing, the initial investment is to gather data elements into one set. Since most of the data elements are routinely collected under uniform billing, there is no need for a change in the current data collection method. This can lead to some limitations in the data, eg, injury coding and discharge diagnoses, which are often overlooked.² For hospitals who collect data by hand, for the small investment in an emergency department-based personal computer, registration can be computerized using the software. This can lead to greater efficiency in billing. For both computerized and non-computerized hospitals, the establishment of a separate emergency department database for the individual hospital can be used for analysis of ED usage and efficiency (length of stay for different types of patients), as well as quality assurance activities for the department. In addition, even at the individual level, the computerization of the ED log can allow for surveillance of injuries in the catchment population.¹ Many of these functions are provided as preprogrammed reports in the software which is provided by KEMSIS. Computerization and streamlining of registration and billing can lead to a reduction in provider FTEs. Thus the initial expenditure may be offset in personnel savings.

Finally, in any data system, reporting must adhere to national and state standards. National standards for prehospital reporting have recently been published.²¹ The state EMS branch is committed to the incorporation of all essential data

elements into the mandatory prehospital reporting. All software provided by KEMSIS will accommodate these standards. In addition, other standards for data collection on specific patients have been published.⁸ The KEMSIS system will also adhere to these guidelines. For emergency departments, there is no uniform standard for data reporting. Recently a national workshop has been convened for the purpose of establishing a standard for uniform emergency department data.²² This set does not define essential elements of reporting, but rather will standardize the type and form of the data elements. The KEMSIS system will conform to these standards.

There are rewards to individual providers and to the state in reporting to and maintaining a central registry for prehospital and emergency department data. We hope that the ease of reporting and the minimal expense for becoming part of the KEMSIS system will spur more hospitals and prehospital providers to join in the effort. With the inclusion of more hospitals and prehospital providers in the reporting of data to KEMSIS, true population-based data for a large geographic area and wide range of patient types will be possible.

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Information for Authors

Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

Copyright assignment — In view of The Copyright Revision Act of 1976, effective January 1, 1978, transmittal letters to the editor must contain the following language and must be signed by all authors: "In consideration of *The Journal of the Kentucky Medical Association* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to *The Journal* in the event that such work is published by *The Journal*."

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Illustrations — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

Editorials and Letters — Should be written in clear, concise language. Length should be about two pages typed with double spacing. Letters will be published at the discretion of the Editorial Board.

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A. Evan Overstreet, MD, Editor

In 1997, Editor A. Evan Overstreet, MD, celebrates his 25th Anniversary as a member of the Board of the Journal of the Kentucky Medical Association. For 20 of these years Dr Overstreet has served as Editor. In recognition of this outstanding contribution, the 1997 KMA House of Delegates honored him with a special tributary resolution, which he proudly displays in the above photo.

It is estimated that Dr Overstreet has attended over 300 meetings of the Editorial Board and has written more than 50 editorials. On the occasion of this special anniversary, the Journal is reprinting the very first editorial contributed by Editor Overstreet, which was published in the January 1973 JKMA.

— Managing Editor

Consumerism

The Great American Consumer Movement is stalking the Great American Health Delivery Industry and our efforts to understand and influence such devices as health insurance, health maintenance organizations, foundations for medical care and federal government participation will be diluted by the necessity for us to attend to consumerism. It is not our ability to successfully relate to the actual consumer, the patient in bed before us, which will generate dispute but the ability of committees of physicians relating to the consumer's advocate. The advocate's stature is very large by virtue of his taking, or being given, identity with consumers of whom there is a population explosion.

On October 28, 1972, in Memphis at the joint meeting of the Tennessee and Kentucky Societies of Internal Medicine, the T.S.I.M. presented a panel entitled *Consumerism in Medicine — an Exercise in Bio — Medico — Prolepsis*. Gerald I. Plitman, M.D., moderated the panel, otherwise composed of Morton D. Bogdonoff, M.D., chairman of the Department of Medicine, University of Illinois and editor of the *Archives of Internal Medicine*; Mr. Richard Johnson, Regional Director of Medicare — Medicaid Administration, Equitable Life Assurance Company, Nashville; John D. Young, M.D., Past President, Tennessee Society of Internal Medicine, Memphis; Gene H. Stollerman, M.D., chairman, Department of Medicine, University of Tennessee College of Medicine,

Memphis, and William C. Felch, M.D., President-Elect, American Society of Internal Medicine, Rye, N.Y.

The panelists agreed they had not previously dealt with this subject and agreed that deal with it we must — that it will not simply go away if ignored.

Consumers were identified as variable from the most intimate, the patient, to the most remote, the Federal Government and intermediary degrees: the physician's office staff, the hospital staff, the hospital administration, insurance carriers and students of medicine.

The government. A central problem, as usual, is proper communication. If indeed representatives of medicine and government are in heated disagreement, they may be talking and thinking on disparate levels of a subject so that agreement is impossible because grievances overshadow the purpose of trying to solve one problem. When one accepts the actual necessity of communicating with the government, bitterness must be exorcised. Another pertinent point is that medicine tends to deal with government's elected officials. These good public servants are subject to variable tenures and even when in greatest power are necessarily influenced tremendously by the members of bureaucracy who are permanent members of government and have a very distinctive power. They need to be talked with as well. The American Society of Internal Medicine is trying to do this.

The emergence of "the fourth party," doctors unionized, may be

another means of communication with government but, at first blush and considering historical union methods, would seem unlikely to lead to the *reasonable agreements* which are going to be essential between government and medicine.

The patient. Is he satisfied with the medical care he receives and the price that is paid? The more the third party involvement, probably the less the patient's concern for cost but here the consumer's advocate involves himself and such patient apathy may be the soundest basis for the consumer advocate despite the seeming paradox. An

example is concern that a part of this patient's bill pays for education of physicians and this education had no direct influence on the patient's care.

The care the patient receives, however, is a subject which always interests him. He mourns the loss of the old time complete doctor. He wants the very best but does not like to be segmented into organs. Besieged by four doctors instead of one, he is confused by values and procedures he wants to understand but cannot.

Doctor Stollerman wisely compared the patient and his doctor to a child and his father. The father does not

angrily refuse the child what he thinks he wants but with patience guides the child to what he really wants. We do this, doctor and patient, everyday. We complain among ourselves that we must communicate to patients patiently but we are proud of how well we do it. The patient's advocate will require much more of this.

And now for prolepsis: the representation or assumption of a future act or development as if presently existing or accomplished. BE PREPARED!

A. Evan Overstreet, M.D.

Season's Greetings

Don & Joan Barton, Corbin
 Scott & Maggie Becker, Villa Hills
 Jack & Vicky Borders, Ashland
 David & Debbie Bruenderman, Louisville
 Nancy & Tom Bunnell, Edgewood
 Dr & Mrs Harry W. Carloss, Paducah
 Keith & Audrey Carter, Louisville
 Danny & Joyce Clark, Somerset
 Dr & Mrs James Crase, Somerset
 Carolyn & Gil Daley, Hazard
 Aroona & Uday Dave, Madisonville
 Angela & Bob DeWeese, Louisville
 Beryl & Dick Dodds, Madisonville
 Mary & Carl Evans, Lexington

Mary & Rob Falk, Louisville
 Ann Faris, Winston-Salem, NC
 Dr & Mrs John F. Gilbert, Hazard
 Carol & Bob Goodin, Louisville
 Gloria Griffin, Louisville
 Malcolm & Karen King, Ashland
 Will & Donna Kruger, Louisville
 Bill & Winnie Mitchell
 Gerry & Wally Montgomery, Paducah
 Dr & Mrs John J. Ryan, Louisville
 Drs Donald & Nancy Swikert, Florence
 Louis & Marla Vieillard, Russell
 Dr William P. VonderHaar, Louisville
 Dr & Mrs James Wagenaar, Ashland

The American Medical Association Education and Research Foundation was established 46 years ago to help medical schools reduce an operating deficit of \$10 million a year. The AMA Alliance has helped to raise over \$1 million a year for the Foundation. The total raised is \$67 million for AMA-ERF which supports education and research in our medical schools. These contributions to AMA-ERF are a legacy of one generation of physicians and their families to the next generation. AMA-ERF supports the future of American medicine.



Carolyn Daley
 AMA-ERF Chair



Carolyn Daley

My request of you during this celebration of New Year and Holiday Season is to continue your excellence with enthusiasm! Your proactive attitude, your diversity and dedication energize me. As I crisscross this beautiful state installing officers, visiting with you at the Fall Board '97, visiting your meetings and fund raisers, and events like the candlelight vigils, I am consistently overwhelmed at the love, respect, and care you extend to each other and to me. Power of one does make a difference and that is what I am trying to accomplish for this fantastic organization.

We are caring physicians' spouses trying to forge a working coalition with other organizations for quality health care as we move towards the next millennium by ringing in 1998.

A special wish from me and my family — Uday, Nishu, Manisha, and Christopher — to you and yours for a very Happy, Healthy, and Joyous 1998.

Fondly,
 Aroona
 KMAA President



Aroona Dave



Clockwise from top left: C. Kenneth Peters, MD, took the oath as the 147th President of the Kentucky Medical Association, administered by Harry W. Carloss, MD, Board Chair; President-Elect Donald R. Stephens, MD, and his wife Sonia were escorted to the podium by Past Presidents Robert R. Goodin, MD, and Donald C. Barton, MD; President Peters is pictured with, L to R, Secretary-Treasurer William P. VonderHaar, MD, President-Elect Stephens, and Board Chair Carloss; Dr Peters and his lovely wife Rhoda were beaming following his inauguration; Kentucky's Lt Governor Steve Henry, MD, congratulated President Peters as Dr Carloss looked on; Dr Peters presented the Past President's plaque to outgoing President William H. Mitchell, MD; President Peters narrated his inaugural message — a big-screen video presentation.

147TH KMA





ANNUAL MEETING





Top: Dr and Mrs Peters' three children shared in the excitement of their father's inauguration. They are, L to R, son Chris Peters, MD, daughters Anne and Elaine, and Elaine's husband, David Waxman. Right: Awards Chair Richard F. Hench, MD, presented the KMA Lay Person Award to Cornelia Atherton Serpell of Louisville. Bottom: Immediate Past First Lady Winnie Mitchell, R, congratulated the new First Lady, Rhoda Peters; KMA's most prestigious honor, the DSA Award was bestowed upon Dwight L. Blackburn, MD.



Inauguration

C Kenneth Peters, MD, a Jeffersontown family physician, was inaugurated 1997-98 President of KMA at the 147th Annual Meeting held in Louisville, September 15-17. A 1960 graduate of the University of Louisville School of Medicine, Dr Peters is a Past President of the Jefferson County Medical Society and served KMA as Vice Speaker of the House from 1989 until 1994, when he was elected Speaker. He subsequently was named President-Elect. Dr Peters has also served as KEMPAC Chair, on the State Legislative Committee for 18 years, and as a KMA Delegate for 21 years. He is a member of the KMA Membership Task Force, Committee on Professional Liability Insurance, Public Education Committee, and Scientific Program Committee.

Dr Peters is a Charter Fellow of the American Academy of Family Practice and a member of the National Association of Occupational Physicians.

Board of Trustees — Elections

The KMA Board of Trustees held its reorganizational meeting for the 1997-98 Association year on September 18, 1996. Acting Chair William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers. Donald R. Stephens, MD, Cynthiana, has been named President-Elect, and Harry W. Carlross, MD, Paducah, was elected Vice President. Newly elected Trustees were Robert C. Hughes, MD, Murray, 1st District; John M. Patterson, MD, Frankfort, 7th District; and Andrew R. Pulito, MD, Lexington, 10th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1997-98 KMA year. J. Gregory Cooper, MD, Cynthiana, was elected Chair, Board of Trustees, and Donald R. Neel, MD, Owensboro, was reelected



Vice Chair. Kenneth R. Hauswald, MD, Ashland, and Thomas E. Bunnell, MD, Crestview Hills, were named as Trustees-at-large.

The next meeting of the Board was scheduled for December 17-18, 1997.

Five physicians were elected by the House of Delegates to serve on the 1998 Nominating Committee. Members elected were:

Susan M. Berberich, MD, Louisville,
Chair

Lucian Y. Moreman, MD, Elizabethtown

Mary Jo Ratliff, MD, Pikeville

Dennis B. Kelly, MD, Lexington

John S. Cave, MD, Henderson

President's Luncheon

The President's Luncheon guests honored outgoing President William H. Mitchell, MD, and witnessed the installation of C. Kenneth Peters, MD, as the 147th President of KMA.

Dr Peters' inaugural message, "Back to the Future," was presented via big-screen video. Adhering to a major goal of his presidency to involve all KMA members — he shared the spotlight with several KMA colleagues. His opening comments included:

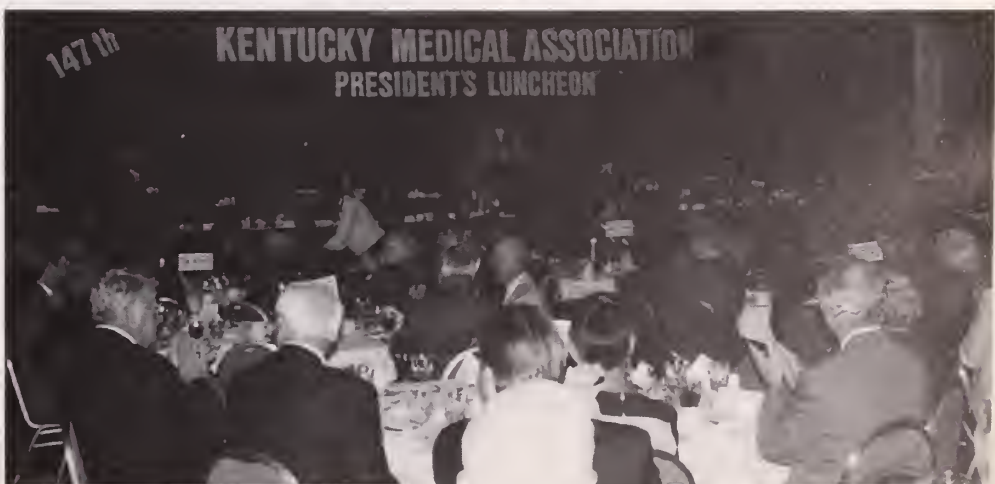
"I am honored to share with you today. It is a unique time in history for all of us. . . . To borrow from Dickens, both the best and worst of times.

"As physicians, we have to master the skill of traversing multiple dimensions of time. We must simultaneously consider a patient's history, assess his or her condition in the present, and help him or her plan for future needs and goals. Likewise, we need to take a page from our own work habits and apply these to how we think about our profession and its role in the post-industrial world. We must learn from the past (without staying in it). We must be active in the present. And we must also simultaneously create a vision for what our future should be — *our future* as a profession and its role in the larger society.

"This process must be undertaken collectively. With that goal in mind, I



Left: Lt Governor Steve Henry congratulated Mrs Peters. Center: Past President Danny M. Clark, MD, was honored with a special resolution by the House of Delegates. Making the presentation was House Speaker John W. McClellan, MD. Vice Speaker Thomas K. Slabaugh, MD, applauds the honor. Bottom: An overflow crowd attended the President's Luncheon.





have collected several of our own voices here today to start us on that journey.

"As we reflect on our past, we would do well to remember a voice from our past — that of the young reformer, Nathan Davis, who in 1847 at the age of 29 founded the American Medical Association.

"Dr Davis said, 'As physicians, we must have a code of ethics. We have a

responsibility to our patients. We have a responsibility to our colleagues. And we have a responsibility to the public.'"

The narrative of Dr Peters' video presentation is printed in its entirety in the October 1997 *Journal*.

DSA Award

Each year the Kentucky Medical Association presents the Association's highest award to a member who has served their community, their state, and their profession with honor.

The 1997 recipient of the Association's most prestigious honor, the Distinguished Service Award, was bestowed upon Dwight L. Blackburn, MD, a retired Madison County general practitioner. He was honored at the President's Luncheon not only for his contributions to the profession but also to his community.

Dr Blackburn is a Past President of the Madison County Medical Society; served two terms on the KMA Board of Trustees from the 11th District; was elected Chair of the Board of Trustees for two consecutive terms; was extremely active in the formation, establishment and operation of the Kentucky Medical Insurance Company and KMA Insurance Agency; and in 1982 was installed as President of the Kentucky Medical Association.

In presenting the award to Dr Blackburn, Awards Chair Richard F. Hench, MD, of Lexington included these comments:

"Active in civic and medical community affairs, our 1997 award recipient was particularly interested in improving the quality of education. He served on the Berea Board of Education as Chairman for 12 years, and was also Chairman of the Central Kentucky School Board Association for 2 years. Our honoree is deeply devoted to his alma mater, and served on the Berea College Board of Trustees for 6 years. He was a member of the Berea College Alumni Association for 7 years and served as its President in 1969. In honor of his work, his community



Among the many President's Luncheon guests were, top, State Senator Tim Shaughnessy; center, L to R, KMA Alliance President Aroona Dave and her husband Dr Uday Dave; and Jefferson County Commissioner David Armstrong. Bottom: William O. Witt, MD, University of Kentucky Department of Anesthesiology, commented on a resolution before the House.

bestowed upon him Citizen of the Year in 1963 and Man of the Year in 1973. Berea College presented him its Award of Special Merit in 1970 and further honored him with their distinguished Alumnus Award in 1976.

"During his term as President, Dr Blackburn distinguished himself by constantly urging members to provide care for the poor and needy despite their ability to pay. At that time there was a downturn in the US economy and many Americans were out of work and without health insurance. Dr Blackburn was also a recipient of KMA's Rural Kentucky Medical Scholarship Fund, and during his tenure as a member of the KMA Board, he never forgot his roots and the need to place physicians in the neediest areas of Kentucky, particularly Appalachia."

Lay Person Award

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, was presented to Cornelia Atherton Serpell of Louisville on behalf of the thousands of patients who have benefitted from her work and personal concern.



Top: Newly elected Board Chair J. Gregory Cooper, MD, Cynthia Ryan, had input on a resolution being considered by the Board; 1996-97 KMA Alliance President Ruth Ryan, Louisville, addressed the House. Center: Relaxing during a break in House action were Delegates, L to R, John S. Cave, MD, Henderson, and Arnold M. Belker, MD, and Molloy G. Veal, MD, both of Louisville. Bottom: AMA President Percy Wootton, MD, addressed the House of Delegates.

Top: Joseph J. Dobner, MD, an orthopedic surgeon from Frankfort, discussed a resolution before the House. Center: Richard E. Park, MD, a Covington anesthesiologist, added his comments about House action. Bottom: Charles E. Bea, MD, Glasgow, was seated with Pike County Delegates, L to R, Baretta R. Casey, MD, Gregory V. Hazelett, DO, and 14th District Trustee E. D. Roberts, MD.

Awards Chair Hensch noted the following in his presentation of the award to Ms Serpell:

"The KMA Awards Committee is pleased to present the Outstanding Layperson Award to Cornelia Atherton Serpell of Louisville. Ms Serpell is a native of Glenview, Kentucky, and a graduate of Sarah Lawrence College. While Ms Serpell has been involved in numerous activities, she has been perhaps Kentucky's leading and most profound advocate of the mentally ill for over 60 years. Her interest and concern for the mentally ill began when she served as a volunteer at Central State Hospital, where she organized recreational programs, raised funds for salaries and supplies, and began raising the conscience of Kentucky over the plight of the mentally ill. Recognizing the horror, maltreatment, and the warehousing of the mentally ill, our recipient set out to change the manner in which government treated those suffering from mental illness. Working with the late Barry Bingham, Sr and Spafford Ackery, MD, she established the Kentucky Association of Mental Health.

Through that framework these visionaries lobbied the legislature for start-up funding for the Department of Mental Health, which had been a stepchild of the Welfare Department. Since that time she has worked tirelessly with mental facilities, physicians, and other practitioners, along with the public, to improve the quality and access to mental health care.

"Cornelia Serpell has served on the Boards of the Louisville Junior League, Blue Cross Blue Shield, Louisville General Hospital, and the Kentucky Board of Medical Licensure. The Awards Committee believes that Cornelia Serpell exemplifies the values, work ethic, and the integrity envisioned when this award was established. Several years ago, Central State Hospital dedicated to our honoree the Serpell Activity Center Wing. At that auspicious occasion, remarks from Senator David Karem were read which we believe best illustrate this compassionate person we honor here today. I quote from Senator Karem's letter. 'This building which you dedicate today springs from the foundation she began laying so many years ago. Each brick speaks for an action, a phone call, a letter, a hand she shook, or a consciousness she raised on behalf of one of the most misunderstood diseases of civilization. Each door represents a mind she opened, and each window offers a view for a better day.'

Educational Achievement Award

The recipient of the 1997 KMA Educational Achievement Award was Billy F. Andrews, MD, Chair Emeritus, Department of Pediatrics, University of Louisville School of Medicine, and Chief of Staff Emeritus, Department of Pediatrics, Kosair Children's Hospital.

Dr Andrews' life and career have been dedicated to teaching of medicine in settings ranging from clinics, hospital wards, newborn nurseries, neonatal intensive care units,



Top: Billy F. Andrews, MD, a Louisville pediatrician, was honored with the Educational Achievement Award and is pictured addressing the House of Delegates. Center: Nelson County Delegate Deborah B. Mattingly, MD, second from left, joined Pike County Delegates, L to R, Lela C. Maynard, MD, Mary J. Ratliff, MD, and Gregory V. Hazelett, MD. Bottom: Jefferson County Delegates James E. Redmon, MD, Susan G. Bornstein, MD, and Barbara S. Isaacs, MD, were pictured during a short recess in House activities.

and classrooms and conferences at the local, state, national, and international levels.

He is Board Certified in Pediatrics and is a Fellow of the American Academy of Pediatrics and a Fellow of the American College of Physicians. His professional involvement includes service on the Executive Committee and the Accreditation Committee of Kosair Children's Hospital from 1969-1993; a consultant to the Division of Maternal and Child Health, Department of Health, 1966-present; Member of the Board Clinical Service Association, University of Louisville School of Medicine 1966-93.

He has been a active member of the Jefferson County Medical Society, the Kentucky Pediatric Society, the Kentucky Medical Association, and the American Pediatric Society, to name a few.

In 1966, he initiated the Newborn Conference, the first of its kind in the nation. In 1968, he established Kentucky's first Neonatal Intensive Care Unit at Louisville General Hospital. In 1968, he was a recipient of a federal grant to establish the Children and Youth Project's Comprehensive Health Center for high risk infants and children. This center has trained many students and residents in preventive child health and health care of the medically fragile patient population.

He has had many special honors including the prestigious Winston Churchill Award of the Wisdom Society for his contributions to medicine, education, and literature. In 1978, he received the Norton/Children's Hospital Award for Leadership in Neonatology, and in 1984, he received an award for Service to Children and Dedication to Education of Osteopathic Pediatricians of the American College of Osteopathic Pediatricians.

In one of the numerous letters of support received, Dr Andrews' teaching method was described as follows, "Dr Andrews taught his students honesty and humility. One learns that it is never

a weakness to say 'I don't know' and that the best approach to patient management is 'first do no harm.' I always remember him saying, 'the level of civilization attained by any society will be determined by the attention it has paid to the welfare of its children.'"





An outstanding group of guest speakers addressed a capacity crowd in the General Sessions hall.

Alliance AMA-ERF

During the first meeting of the House of Delegates, Ruth Ryan, KMA Past President, advised that AMA-ERF checks had been presented to the two medical schools on behalf of the Alliance. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding \$2 million annually. The extraordinary fund raising efforts of the AMA Alliance and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. This year the University of Louisville School of Medicine received an AMA-ERF check for \$20,926.38, and the University of Kentucky College of Medicine, received an AMA-ERF check for \$13,675.10.

Fifty-Year Members

Those KMA member physicians who have been practicing medicine for 50

years or more were recognized during the President's Luncheon. Achieving that status this year are: Drs Warren H. Ash, Joseph W. Blevins, Thomas D. Brower, Mario W. Cartaya, Dale E. Dunkelberger, Joel Elkes, Earl J. Farrell, Doane Fischer, Maurice M. Hall, Edward K. Hand, William E. Hopkins, O. James Hurt, James M. Keightley, Paul H. Klingenberg, Robert C. Kratz, John A. Naber, M. David Orrahood, Elizabeth Y. Pakk, M. D. Phelps, Philip E. Podruch, Bernard I. Popham, Everett N. Rush, John B. Rypstra, William F. Schnitzker, James A. Schroer, Harold J. Schubach, Ellsworth C. Seeley, John Woodrow Simmons, Orson P. Smith, Loman C. Trover, Stuart Urbach, Paul K. Wellman, James O. Willoughby, Edgar D. Wippermann and M. Harper Wright.

In Memoriam

During the first House of Delegates meeting, Secretary-Treasurer William P. VonderHaar, MD, requested that the audience stand for a moment of silence in memory of those physician members who had died in the last year. A list of

the deceased appears on page — of this *Journal*.

KMA-MSS and RPS

The KMA Medical Student Section and Resident Physician Section held a joint meeting on September 16 on "Will GME Funding Changes Affect Residency Selection?" Wes Dunaway, MD, President of the KMA-RPS, coordinated plans for the session, which featured a panel moderated by Robert R. Goodin, MD, Louisville, a member of the AMA Council on Medical Education.

Panelists included Alfred L. Thompson, Jr, MD, Associate Dean for Clinical Affairs at UL, and James C. Norton, PhD, Associate Dean for Extramural/Postgraduate Medical Education at UK.

KEMPAC

The 35th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 15, at the Hyatt Regency Hotel, Louisville. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff heard opening remarks by KMA President William H. Mitchell, MD, and the featured speaker, Stuart Rothenberg, a political analyst from Washington, DC. Charles Garrett, MD, representing AMPAC, presented KEMPAC an award for achieving the 1996 AMPAC membership goal. KEMPAC Chair, William B. Monnig, MD, Edgewood, presided at the meeting.

House Action Summary

The Association's policymaking body, the House of Delegates, met on September 15 and again on September 17 and considered more than 40 reports, 36 Resolutions, and several organizational and special reports. Highlights of House actions are listed below. Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

- Work to restore historical funding of the KenPAC monthly case management fee under Medicaid
- Urge the Kentucky Board of Medical Licensure to require non-resident physicians practicing telemedicine in the state to have a full license
- Urge physicians and spouses to support the AMA-Education and Research Foundation with charitable donations
- Declared the administration of anesthesia to be the practice of medicine and where possible epidural, spinal and general anesthesia should be administered by a trained physician
- Called for the licensure of insurance company medical directors and employees of carriers and managed care companies who make decisions that result in patient injury so that they can be held legally responsible for those decisions
- Asked the Board of Trustees to consider the establishment of a section on International Medical Graduates.
- Directed the Board of Trustees to develop a policy on changing the postgraduate training requirement for licensure to two years for physician applicants from schools outside the United States or Canada
- Work to repeal any statutory requirements for continuing medical education for "disease and topic-specific" issues
- Declared it unethical for physicians to participate in executions except to certify cause of death
- Work to seek statutory prohibition of "gag clauses"
- Consider the study of the practice of alternative and unconventional medicine
- Work for parity of mental health benefits equal to benefits for other illnesses in health insurance coverage
- Directed the Board of Trustees to develop a position on the national "tobacco settlement" issue
- Recognized Danny M. Clark, MD,



Newly installed President Ken Peters gave a "thumbs up" at the House of Delegates as Secretary-Treasurer Bill Vonderhaar, MD, made opening remarks. Other officers, L to R, Vice Speaker Thomas Slabaugh, Board Chair Harry Carloss, Immediate Past President Bill Mitchell, President-Elect Don Stephens, and Vice Chair Don Neel. The House of Delegates and the entire Annual Meeting program earned a "thumbs up."

- Somerset, for his years of service to KMA and the profession.
- Recognized A. Evan Overstreet, MD, Louisville for his years of service as Editor of the *KMA Journal*
- Recognized Stephen Z. Smith, MD, Louisville and Milton F. Miller, MD, Louisville for their years of service as members of the Editorial Board of the *KMA Journal*

Attendance

This year's KMA meeting attracted a crowd of 2,380. Physicians numbered 1,135 and medical students 119,

resulting in a very successful 147th KMA Annual Meeting at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. The 1998 Annual Meeting will also be held in Louisville. The Board of Trustees has again selected the very accommodating and spacious Hyatt Regency Hotel/Commonwealth Convention Center to house the meeting. Over 22 specialty groups and an estimated 2,600 registrants are expected to attend.

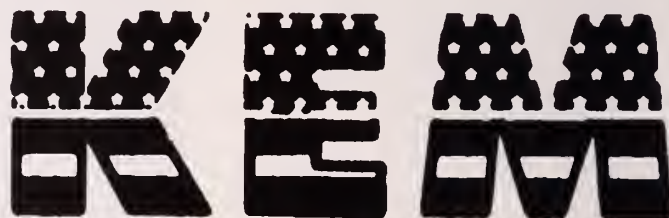
Please mark your calendars to attend the 1998 KMA Annual Meeting to be held September 21-23.



L to R, Past KEMPAC Board member Faye Neel and KMA Board Vice Chair Donald R. Neel, MD; Lt Governor Steve Henry, MD; KEMPAC Secretary Tom Maddox, MD.



KEMPAC Vice Chair Robert Woods, II, MD; State Senator Tom Buford.



KEMPAC Treasurer Michael Dee, MD; State Senator Julie Rose.



L to R, Doug Scutchfield, MD; Ernie Fletcher, MD, candidate for Congress; Stan Cave, Minority Leader, Kentucky House of Representatives; Preston P. Nunnelley, MD, Immediate Past KEMPAC Treasurer.



Dr Donald C. Barton and his wife Joan, L, are pictured with AMA President Percy Wootton, MD, and his wife Dr Jane Wootton.

A distinguished group of KMA members, and the KEMPAC Seminar Banquet Meeting. KEMPAC Chair presided at the meeting. pictured in this th



Charles Garrett, MD, representing AMPAC, presented a membership award to KEMPAC Chair William B. Mannig, MD.



L to R, 8th KMA District Trustee Thomas E. Bunnell, MD, and his wife Nancy are pictured with KEMPAC Baard member Glaria Griffin.



KMA Executive Vice President William T. Applegate, L, is seated with State Representative Bob M. DeWeese, MD, and his wife Angie.



AMA President Dr Percy Waattan and KMA Past President Dr Ardis D. Hoven.

o of state leaders,
spouses attended the
held during the Annual
William B. Monnig, MD,
veral in attendance are
e-page feature.



KMA Past President Robert R. Goodin, MD, and his wife Carol are joined by AMA President Waattan and his wife Dr Jane Wootton.



Immediate Past KEMPAC Chair William P. VonderHaar, MD, L, was seated with Lt Governor Henry and his staff assistant, Stacy Fritz.



Dr Charles C. Smith and his wife Rosemary, L, are pictured with Dr Susan Bornstein.

KEMPAC



L to R, KEMPAC Board member Charles T. Watson, MD, his wife Pam, and 13th District Trustee Kenneth R. Hauswald, MD.



KEMPAC Board member John E. Downey, MD, L, enjoyed the evening with Dr James D. Crase and his wife Jan, President-Elect of the KMA Alliance.



Above: Preston P. Nunnolley, MD, past KEMPAC treasurer, was seated with State Representative Jesse Crenshaw. Left: Russell L. Travis, MD, and his wife Jill, L, were seated with Senator John "Eck" Rose and his wife Jill.

**1998 KMA LEGISLATIVE SEMINAR
JANUARY 28, 1998
CAPITAL PLAZA HOTEL
FRANKFORT, KENTUCKY**

- 8:00 to 8:30 C. Kenneth Peters, MD, President, Presiding
Continental Breakfast
- 8:30 to 9:00 Governor Paul E. Patton
State of the Commonwealth
Donald R. Stephens, MD, President-Elect, Presiding
- 9:00 to 9:20 Senator Dan Kelly, Senate Minority Floor Leader
The 1998 Session - The Minority Party Perspective
- 9:20 to 9:40 Representative Jody Richards, Speaker of the House
The 1998 Session - The Speaker's Perspective
- 9:40 to 10:00 Senator Larry L. Saunders, President of the Senate
The 1998 Session-The President's Perspective
- 10:00 to 10:15 BREAK
- 10:15 to 10:45 William P. VonderHaar, MD, Secretary-Treasurer, Presiding
Mr. George Nichols, Commissioner, Department of Insurance
Health Insurance Reform
- 10:45 to 11:00 Representative Bob M. DeWeese, MD
Health Care Legislative Priorities in 1998
- 11:00 to 11:15 William B. Monnig, MD, KEMPAC Chairman
Political Realities
- 11:15 to 11:45 Wally O. Montgomery, MD
Chair, Committee on State Legislative Activities
KMA's Legislative Agenda
- 11:45 to 12:00 Mrs. Angie DeWeese, Vice President, KMAA
Alliance Priorities and Programs for the 1998 Session
J. Gregory Cooper, MD, Chair, Board of Trustees, Presiding
- 12:00 to 12:30 LUNCH
- 12:30 to 1:00 Mr. John H. Morse Secretary, Cabinet for Health Services
Medicaid Partnerships, CON, and Health Departments
- 1:00 to 1:10 Preston P. Nunnelley, MD
Vice Chair, Committee on State Legislative Activities
Lobbying Is A Contact Sport

**REGISTRATION IS FREE FOR PHYSICIANS, SPOUSES,
AND OFFICE STAFF. HOWEVER, YOU MUST
PRE-REGISTER BY CALLING (502) 426-6200.**

ROLL CALL

1997 House of Delegates

1st Meeting September 15, 1997

2nd Meeting September 17, 1997

OFFICERS

		First Meeting	Second Meeting
Speaker.....	John W. McClellon, Jr, MD	Present	Present
Vice Speaker.....	Thomas K. Slobough, MD	Present	Present
President.....	William H. Mitchell, MD	Present	Present
President-Elect.....	C. Kenneth Peters, MD	Present	Present
Vice-President.....	Donald R. Stephens, MD	Present	Present
Secretary-Treasurer.....	William P. VonderHoor, MD	Present	Present
AMA Delegate.....	Donald C. Borton, MD	Present	Present
AMA Delegate.....	Wally O. Montgomery, MD	Present	Present
AMA Delegate.....	Robert R. Goodin, MD	Present	Present
AMA Delegate.....	Ardis D. Hoven, MD	Present	Present
AMA Delegate.....	Donald J. Swikert, MD	Present	Present
AMA Alternate Delegate.....	Bob M. DeWeese, MD	Present	Present
AMA Alternate Delegate.....	J. Gregory Cooper, MD	Present	Present
AMA Alternate Delegate.....	Preston P. Nunnelley, MD	Present	Present
AMA Alternate Delegate.....	William B. Monnig, MD	Present	Present
AMA Alternate Delegate.....	Boretta R. Casey, MD	Present	Present

TRUSTEES

District		First Meeting	Second Meeting
First District.....	Harry W. Corlass, MD	Present	Present
Second District.....	Donald R. Neel, MD	Present	Present
Third District.....	C. R. Dodds, MD	Present	Present
Fourth District.....	Eugene H. Shively, MD	Present	Present
Fifth District.....	Doniel W. Vorgo, MD	Present	Present
Sixth District.....	Jahn T. Burch, II, MD	Present	Present
Seventh District.....	Ronald E. Woldridge, MD	Present	Present
Eighth District.....	Thomas E. Bunnell, MD	Present	Present
Ninth District.....	J. Gregory Cooper, MD	Present	Present
Tenth District.....	Russell L. Trovis, MD	Present	Present
Eleventh District.....	Richard A. Stone, MD	Present	Present
Twelfth District.....	Donald E. Brawn, MD	Present	Present
Thirteenth District.....	Kenneth R. Houswold, MD	Present	Present
Fourteenth District.....	E. D. Roberts, MD	Present	Present
Fifteenth District.....	Meredith J. Evons, MD	Present	Present

ALTERNATE TRUSTEES

District		First Meeting	Second Meeting
First District.....	Robert C. Hughes, MD	Present	Present
Second District.....	Uday V. Dove, MD	Present	Present
Third District.....	Brion F. Wells, MD	Present	Present
Fourth District.....	Susan M. Berberich, MD	Present	Present
Fifth District.....	J. Michael Pulliom, MD	Present	Present
Sixth District.....	John M. Patterson, MD	Present	Present
Seventh District.....	James P. Forrell, MD	Present	Present
Eighth District.....	Andrew R. Pulito, MD	Present	Present
Ninth District.....	Suvas G. Desoi, MD	Present	Present
Eleventh District.....	Susan H. Prosher, MD	Present	Present
Twelfth District.....	Boretta R. Cosey, MD	Present	Present
Thirteenth District.....	Dovid W. Douglos, MD	Present	Present

PAST PRESIDENTS

		First Meeting	Second Meeting
Post President.....	Donny M. Clark, MD	Present	Present
Post President.....	Robert R. Goodin, MD	Present	Present
Post President.....	Ardis D. Hoven, MD	Present	Present
Post President.....	William B. Monnig, MD	Present	Present
Post President.....	S. Randolph Scheen, MD	Present	Present

DELEGATES FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD.....	Mortho C. Robinson, MD, Borlow	Present	Present
CALLOWAY.....	Robert C. Hughes, MD, Murray	Present	Present
	Rob T. Williams, MD, Murray	Present	Present
CARLISLE.....			
FULTON.....			
GRAVES.....	Charles E. Beo, MD, Mayfield	Present	Present
	Gerald Russell, MD, Mayfield	Present	Present
HICKMAN.....	Bruce C. Smith, MD, Clinton	Present	Present
LIVINGSTON.....	Stephen Burkhort, MD, Salem	Present	Present
MARSHALL.....			
MCCRACKEN.....	Harry Corlass, MD, Paducah	Present	Present
	Peter E. Lacken, MD, Paducah	Present	Present
	Wally Montgomery, MD, Paducah	Present	Present
	Carolyn S. Watson, MD, Paducah	Present	Present

SECOND DISTRICT

DAVIESS.....	Christopher J. Hoveldo, MD, Owensboro	Present	Present
	William Modouss, MD, Owensboro	Present	Present
	R. Wotken Medley, Jr, MD, Owensboro	Present	Present
	William Milnor, MD, Owensboro	Present	Present
	Linda Mumford, MD, Owensboro	Present	Present
	Terry Tyler, MD, Owensboro	Present	Present
	William Tyler, MD, Owensboro	Present	Present
HANCOCK.....			
HENDERSON.....	John S. Cove, MD, Henderson	Present	Present
	Morshall G. Howell, III, MD, Henderson	Present	Present
	Scott Watkins, MD, Henderson	Present	Present
MCLEAN.....			
OHIO.....	Charles L. Price, MD, Hartford	Present	Present
UNION.....			
WEBSTER.....			

THIRD DISTRICT

CALDWELL.....			
CHRISTIAN.....	E. Wayne Masley, MD, Hopkinsville	Present	Present
CRITTENDEN.....			
HOPKINS.....	Wollice R. Alexander, MD, Modisnaville	Present	Present
	James Bowles, MD, Modisnaville	Present	Present
	James M. Donley, MD, Modisnaville	Present	Present
	Uday V. Dove, MD, Modisnaville	Present	Present
	Mohon Roo, MD, Modisnaville	Present	Present

LYON.....			
MUHLBERG.....	William L. Miller, MD, Greenville	Present	Present
TODD.....			
TRIGG.....			

FOURTH DISTRICT

BRECKINRIDGE.....			
BULLITT.....			
GRAYSON.....	William L. Shuffett, MD, Greensburg	Present	Present
GREEN.....	Scott Kooperman, MD, Elizabethtown	Present	Present
HARDIN.....	Lucion Moremon, MD, Elizabethtown	Present	Present
	Jeffrey Richardson, MD, Elizabethtown	Present	Present
	Dovid Zoeller, MD, Elizabethtown	Present	Present
HART.....	Clem Nichols, MD, Mumfordsville	Present	Present
LARUE.....			
MEADE.....	Roymand L. Mothis, DO, Brandenburg	Present	Present
MARION.....	Brion F. Scott, MD, Lebanon	Present	Present
	Solem George, MD, Lebanon	Present	Present
NELSON.....	Deborah Mattingly, MD, Bordstawn	Present	Present
TAYLOR.....	Dovid Mantgomery, MD, Campbellsville	Present	Present
WASHINGTON.....	Julie Brown, MD, Springfield	Present	Present

FIFTH DISTRICT

JEFFERSON	Edward C. Adler, MD, Louisville	Present	
	Dovid T. Allen, MD, Louisville	Present	
	Kenneth C. Anderson, MD, Louisville		
	George R. Aronoff, MD, Louisville		
	Arnold Belker, MD, Louisville	Present	
	Suson M. Berberich, MD, Louisville	Present	
	S. J. Bertolone, Jr, MD, Louisville		
	Charles Bisig, MD, Louisville	Present	
	Dovid H. Bizot, MD, Louisville		
	Horold Blevins, MD, Louisville	Present	
	Steven Bloom, MD, Louisville		
	Suson G. Bornstein, MD, Louisville	Present	
	Peter C. Campbell, MD, Louisville	Present	
	Keith Corter, MD, Louisville		
	Mork Corbett, MD, Louisville		
	Thereso Corrigan, MD, Louisville		
	Warren Cox, MD, Louisville	Present	
	Dovid R. Cundiff, MD, Louisville	Present	
	John H. Doyle, MD, Louisville	Present	
	Rudy J. Ellis, Jr, MD, Louisville	Present	
	Somuel G. Eubanks, MD, Louisville	Present	
	Carolyn B. Gleason, MD, Louisville	Present	
	Lindo H. Gleis, MD, Louisville	Present	
	Leonord Goddy, MD, Louisville		
	Monuel Grimaldi, MD, Louisville	Present	
	Anno K. Huong, MD, Louisville		
	Philip J. Hulsmon, MD, Louisville	Present	Present
	Wolter Hume, MD, Louisville	Present	Present
	Borboro Sue Isoocs, MD, Louisville		Present
	Sheri A. Kolbfleisch, MD, Louisville		Present
	Virginio Keeney, MD, Louisville	Present	Present
	Stephen S. Kirzinger, MD, Louisville	Present	Present
	Glenn Lombert, MD, Louisville		
	Julie Lee, MD, Louisville	Present	
	Charles Mohl, MD, Louisville		
	Michael T. Mocerlone, MD, Louisville	Present	
	James E. McKiernon, Jr, MD, Louisville		
	W. Poul McKinney, MD, Louisville	Present	
	Frank B. Miller, MD, Louisville		
	Alice Minter-Souer, MD, Louisville	Present	
	Rolph C. Morris, MD, Louisville	Present	
	Thomos G. O'Daniel, MD, Louisville		
	Voughn W. Poyné, MD, Louisville	Present	
	Robert L. Pence, MD, Louisville	Present	
	Hugh Peterson, MD, Louisville	Present	
	Mork E. Petrik, MD, Louisville		
	Mork Pfeifer, MD, Louisville		
	Steven J. Roible, MD, Louisville		
	Julio Ramirez, MD, Louisville		
	Bernard O. Rond, MD, Louisville	Present	Present
	James E. Redmon, MD, Louisville	Present	Present
	K. Thomos Reichord, MD, Louisville	Present	Present
	Ben A. Reid, Jr, MD, Louisville		
	Steven J. Reiss, MD, Louisville	Present	
	Williom M. Rendo, MD, Louisville	Present	
	Peter Ross, MD, Louisville		
	Borton H. Reutlinger, MD, Louisville	Present	Present
	Someul R. Scheen, III, MD, Louisville	Present	Present
	G. Rondolph Schrodt, Sr, MD, Louisville		Present
	Edward L. Scofield, MD, Louisville	Present	Present
	Judoh L. Skolnick, MD, Louisville		Present
	Bernard L. Speevock, MD, Louisville		Present
	Eloine Stouble, MD, Louisville		
	Peter Steiner, MD, Louisville	Present	
	Rebecca Terry, MD, Louisville		
	Robert Tillett, MD, Louisville		
	Alfred L. Thompson, MD, Louisville		
	Stuort Urboch, MD, Louisville	Present	

Molloy Veol, MD, Louisville	Present	Present
Gory L. Vitole, MD, Louisville		
Henry Wolter, MD, Louisville		
Norton G. Watermon, MD, Louisville		
Dovid Watkins, MD, Louisville		
Somuel D. Weokley, MD, Louisville	Present	Present
G. Derek Weiss, MD, Louisville		
Fred Williams, MD, Louisville		
Russell A. Williams, MD, Louisville		
C. Milton Young, MD, Louisville	Present	Present

SIXTH DISTRICT

ADAIR			
ALLEN			
BARREN	Worren J. Eisenstein, MD, Glogow		
	William Travis, MD, Glogow		
BUTLER			
CUMBERLAND	Joseph D. Skipworth, MD, Burkesville		
EDMONSON	Omkor N. Bhatt, MD, Brownsville		
LOGAN			
METCALF	Lowrence P. Emberton, MD, Edmonton		
MONROE	James E. Corter, MD, Tompkinsville		
SIMPSON	Michael Pulliom, MD, Franklin	Present	Present
WARREN	James Beattie, MD, Bowling Green	Present	Present
	Mork E. Bigler, MD, Bowling Green		
	Robert Emslie, MD, Bowling Green	Present	Present
	M. Robert Perez, MD, Bowling Green	Present	

SEVENTH DISTRICT

ANDERSON	Kenneth E. Hines, MD, Lowrenceburg		
CARROLL	Cecil D. Mortin, MD, Corrollton		
FRANKLIN	Joseph J. Dobner, MD, Frankfort		Present
	Arbo L. Kenner, MD, Frankfort	Present	Present
	John M. Potterson, MD, Frankfort	Present	Present
GALLATIN	Benjamin Kutnicki, MD, Worsow	Present	Present
GRANT	Doryl Shipp, MD, Dry Ridge		
HENRY	Dovid Wolloce, MD, Shelbyville		
OLDHAM	Brooks Jackson, MD, Shelbyville		
OWEN			
SHELBY	Edward Somes, MD, Shelbyville		
SPENCER	Thomos C. Croin, MD, Taylorsville		
TRIMBLE	Frank Polmer, MD, Bedford	Present	Present

EIGHTH DISTRICT

BOONE	Nancy Swikert, MD, Florence	Present	Present
	Ted Miller, MD, Edgewood	Present	Present
	Neol J. Moser, MD, Crestview Hills		Present
	Allon Hollquist, MD, Edgewood		Present
CAMPBELL	James Evons, MD, Ft. Thomos		Present
	Steve Steinkomp, MD, Edgewood		
KENTON	Gordon W. Air, MD, Crestview Hills	Present	Present
	Chris Bolling, MD, Crestview Hills		Present
	Jim Forrell, MD, Crestview Hills	Present	Present
	Don Fogel, MD, Edgewood		Present
	Stephen L. Hiltz, MD, Covington	Present	
	Joseph C. Mortin, MD, Erlonger		Present
	Ross McHenry, MD, Covington		Present
	Richard E. Pork, MD, Covington		Present

NINTH DISTRICT

BATH			
BOURBON	Emmett L. Tote, MD, Paris	Present	
BRACKEN			
FLEMING	Glenn R. Womock, MD, Flemingsburg		
HARRISON	J. Gregory Cooper, MD, Cynthion	Present	Present

MASON	Leroy Shouse, MD, Moysville	.....	.....
NICHOLAS			
PENDLETON			
ROBERTSON			
SCOTT	Judy Linger, MD, Georgetown	Present	Present

TENTH DISTRICT

FAYETTE	James W. Baker, MD, Lexington	Present	Present
	J. R. Beon, MD, Lexington	Present	Present
	Dovid J. Bensema, MD, Lexington	Present	Present
	Kathleen J. Bos, MD, Lexington	Present	Present
	T. Clark, MD, Lexington	.....	Present
	John W. Collins, MD, Lexington	Present	Present
	W. L. Dalton, MD, Lexington	Present	Present
	James E. Dunnington, MD, Lexington	Present	Present
	E. L. Fletcher, MD, Lexington	Present	Present
	John M. Fox, MD, Lexington	.....	Present
	Kenneth L. Gerson, MD, Lexington	.....	Present
	Bill H. Horris, MD, Lexington	Present	.....
	R. Hench, MD, Lexington	Present	Present
	Tomoro Jones, MD, Lexington	.....	.....
	Mogdolene B. Koron, MD, Lexington	Present	Present
	Dennis B. Kelly, MD, Lexington	Present	Present
	Doniel E. Kenody, Sr, MD, Lexington	Present	Present
	Gerald V. Klim, DO, Lexington	Present	Present
	Nicholas J. Lynn, MD, Lexington	.....	Present
	Andrew M. Moore, II, MD, Lexington	.....	.....
	John M. Moore, MD, Lexington	Present	Present
	Brion Nolan, MD, Lexington	.....	Present
	William N. Offutt, IV, MD, Lexington	.....	Present
	Borboro A. Phillips, MD, Lexington	Present	Present
	John W. Poundstone, MD, Lexington	Present	.....
	Juan Sanchez, MD, Lexington	.....	Present
	Tomoro Sanderson, MD, Lexington	.....	Present
	Not Sandler, MD, Lexington	.....	Present
	F. Douglas Scutchfield, MD, Lexington	Present	Present
	Glenn R. Sheorer, MD, Lexington	.....	Present
	S. E. Spires, MD, Lexington	.....	.....
	David B. Stevens, MD, Lexington	Present	Present
	John D. Stewart, MD, Lexington	Present	Present
	Henry Wells, Jr, MD, Lexington	Present	Present
	John Robert White, MD, Lexington	Present	Present
	Eric Wilson, MD, Lexington	.....	Present
	Emery A. Wilson, MD, Lexington	.....	Present
	William Witt, MD, Lexington	Present	Present
JESSAMINE			
WOODFORD	Angelo Clifford, MD, Versailles	.....	.....

ELEVENTH DISTRICT

CLARK	Doniel Alon Ewen, MD, Winchester	.....	.....
ESTILL	John A. Potterson, MD, Irvine	Present	Present
LEE	James B. Noble, MD, Beattyville	.....	.....
JACKSON			
MADISON	Jerome Krumpelmon, Jr, MD, Richmond	.....	Present
	Richard A. Stone, MD, Richmond	.....	.....
MONTGOMERY	Lon E. Roberts, Jr, MD, Mount Sterling	.....	.....
MENIFEE			
OWSLEY			
POWELL			
WOLFE	Poul Moddcox, MD, Compton	.....	.....

TWELFTH DISTRICT

BOYLE	Dovid C. Liebschutz, MD, Donville	Present	.....
	Arthur K. Rivard, MD, Donville	Present	Present

	Scott Scutchfield, MD, Donville	Present	Present
CASEY			
CLINTON	Michael Lee Cummings, MD, Albony	.....	.....
GARRARD	Paul J. Sides, MD, Lancaster	Present	.....
LINCOLN			
MCCREARY			
MERCER	George Noe, MD, Horrodsburg	.....	.....
PULASKI	Steven M. DeMunbrun, MD, Somerset	Present	Present
	Debro Eodens, MD, Somerset	Present	Present
	James D. Wilson, MD, Somerset	Present	Present
ROCKCASTLE	William D. Dooley, MD, Mount Vernon	.....	.....
RUSSELL	H. Michael Oghio, MD, Russell Springs	.....	.....
WAYNE	Edward Joseph, MD, Monticello	Present	Present

THIRTEENTH DISTRICT

BOYD	Mourice J. Ookley, MD, Ashland	Present	Present
	Roger Potter, MD, Ashland	Present	Present
	Susan Prosher, MD, Ashland	Present	Present
	Charles Watson, MD, Ashland	Present	Present
CARTER			
ELLIOTT			
GREENUP	John O. Jones, MD, Flatwoods	Present	.....
	Manuol Gorcio, MD, Ashland	.....	Present
LAWRENCE	George Corter, MD, Louiso	.....	Present
LEWIS			
MORGAN	James Frederick, MD, Liberty	.....	.....
ROWAN	Tom Newcomb, MD, Morehead	Present	.....

FOURTEENTH DISTRICT

BREATHITT			
FLOYD	Nicholas R. Jurich, MD, Prestonsburg	Present	Present
	Deborah Holl, MD, Prestonsburg	.....	.....
LETCHER			
JOHNSON			
KNOTT	W. Grady Stumbo, MD, Hindmon	.....	.....
MAGOFFIN			
MARTIN			
PERRY	Gilroy Doley, MD, Hozord	Present	Present
	David Krosopolsky, MD, Hozord	.....	.....
PIKE	Gregory Hozelett, DO, Pikeville	Present	Present
	Lelo C. Maynord, MD, Pikeville	Present	Present
	Mary Jo Roliff, MD, Pikeville	Present	Present

FIFTEENTH DISTRICT

BELL	Frank Moppolo, MD, Middlesboro	.....	.....
	Ouen Pongdee, MD, Middlesboro	.....	.....
CLAY	Craig Leicht, MD, Monchester	.....	.....
HARLAN	Gordon Hollins, MD, Horlon	Present	Present
KNOX	Harold L. Bushey, MD, Borbourville	Present	Present
LAUREL	Al Perkins, MD, London	.....	.....
	William D. Proff, MD, London	Present	.....
LESLIE			
WHITLEY	P. Bruce Borton, MD, Corbin	Present	Present
	Kathy Martin, MD, Corbin	.....	.....
	Rod Weisert, MD, Corbin	.....	Present

KMA Student Section

UL	Bryce Schuster, Louisville	.....	.....
UK	Michael R. Dobbs, Lexington	.....	.....

KMA Resident Physicians Section

Beth Former, MD, Louisville	Present	Present
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KMA Organized Medical Staff Section

Goy Fulkerson, MD, Leitchfield	Present	Present
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The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 15 and September 17.

147th ANNUAL MEETING

Kentucky
Medical
Association





Index to Proceedings

Minutes, House of Delegates First Meeting	539
Minutes, House of Delegates Second Meeting	541
Ad Hoc Committee on Faculty Membership	568
Ad Hoc Committee to Develop a Comprehensive School Health Education Plan	577
Alliance, Report of the President	542
Board of Trustees, Chair	544
Board Meetings, Summary of	544
Cancer	554
Care for the Elderly	560
Changing Trends in Medicine, Committee to Investigate	569
Child and School Health	575
Community and Rural Health	576
Continuing Medical Education	556
Council for Continuing Medical Education	553
Delegates to AMA	546
Editor	546
Election of 1998 Nominating Committee	580
Election of Officers	581
Ephraim McDowell Cambus-Kenneth Foundation, Inc.	549
Executive Vice President	547
Interspecialty Council	575
Judicial Council	575
KMA Physicians Plan, Inc	548
KEMPAC Report	566
Kentucky Medical Insurance Company	549
Maternal and Neonatal Health	575
Medical Insurance and Prepayment Plans	566
Medical Student Section	568
Membership Task Force	568
National Legislation	559
Organized Medical Staff Section	555
Physical Education and Medical Aspects of Sports	574
Physician Advisory Committee to Health Kentucky	549
Physician Services (Medicaid), Technical Advisory	573
Physician Workforce Committee	554
President	542
President-Elect	543
PRO Advisory	569
Professional Liability Insurance	560
Proposed Constitutional Amendment	580
Public Education	561
Resident Physicians Section	567
Rural Kentucky Medical Scholarship Fund	556
Scientific Exhibits	553
Scientific Program	553
Secretary-Treasurer	546
Speakers, House of Delegates	544
State Legislative Activities	562
Young Physicians Steering	567

Index to Resolutions

Resolution	Subject	
Tributes	Stephen Z. Smith, MD	540
	Milton F. Miller, MD	540
	Danny M. Clark, MD	541
	A. Evan Overstreet, MD	541
Memorial	John Ed McConnell	541
97-101	Reduction of Tobacco Use While Assuring Community Economic Stability . . .	578
97-102	Community Authority for Reduction of Tobacco Use by Children	578
97-103	Mandatory HIV Education for Physicians	563
97-104	Insulin as a Prescription Drug	557
97-105	KMA Scientific Session Speakers	557
97-106	Dues-Free Membership for Resident Physicians	571
97-107	Shifting of Administrative Burdens by Insurance Companies	571
97-108	Medicare Audits	564
97-109	Formation of a KMA Committee to Promote AMA-ERF	550
97-110	Anesthesia	558
97-111	Smoking in Children	578
97-112	Medicaid Funding: KenPAC Primary Care Management Fee	550
97-113	High School Start Times	551
97-115	Medical Practice Business Expenses	572
97-116	Brooks vs KBML Amicus Brief	551
97-117	Revision of KRS 311	551
97-118	Alternative Medical Practice	572
97-119	Health Carriers' and Managed Care Organizations' Tort Liability	558
97-120	Mandatory Domestic Violence Educational Requirements for Primary Care Physicians	564
97-121	KMA International Medical Graduates (IMG) Section	558
97-122	Training Requirements for Medical Licensure	559
97-123	Parity for Mental Illness in Medical Benefits Programs	572
97-124	Kentucky Forest Stewardship Act	552
97-125	Commercial Poultry and Swine Industry	579
97-126	Mandatory Domestic Violence Education for Primary Care Physicians	564
97-127	Full Licensure for Telemedicine Physicians	552
97-128	Unlicensed Practice	558
97-129	Reaffirmation of Resolution R (1995)	572
97-130	Phen-Fen Prescriptions	580
97-131	Physician Participation in Capital Punishment	564
97-132	Fraud and Abuse	565
97-133	Gag Clauses	565
97-134	Mandatory Provisions in Health Insurance Policies	572
97-135	Sale of Tobacco	578
97-136	Tobacco Settlement	580

Reference Committees

Special appreciation to the Chairs and members of the Reference Committees for working so diligently to study committee reports, resolutions, and make recommendations to the full House of Delegates.



(L to R) Reference Committee A: Gay Fulkerson, MD, Leitchfield (OMSS); Gordon W. Air, MD, Crestview Hills; David J. Zaeller, MD, Elizabethtown, Chair; James R. Bean, MD, Lexington; Joseph J. Dobner, MD, Frankfort. Not pictured, Susan G. Barnstein, MD, Louisville.



Reference Committee B: Bryce E. Schuster, Louisville (MSS); Mohan K. Raa, MD, Madisanville; James P. Farrell, MD, Crestview Hills; Kathleen J. Bros, MD, Lexington, Chair. Not pictured, Gilray L. Daley, MD, Hazard.



Reference Committee C: Robert C. Hughes, MD, Murray; James F. Beattie, Jr, MD, Bowling Green; Lela C. Maynard, MD, Pikeville, Chair; Nicholas R. Jurich, MD, Prestansburg; Arthur K. Rivard, MD, Danville; Jahn R. White, MD, Lexington.



Reference Committee D: K. Thomas Reichard, MD, Chair; John D. Stewart, II, MD, Lexington; Judy M. Linger, MD, Georgetown; Elizabeth A. Farmer, MD, Louisville (RPS); Jerame L. Krumpelman, Jr, MD, Richmond; Deborah B. Mattingly, MD, Bardstawn.



Reference Cammittee E: Edward L. Scafield, MD, Louisville; Cecil D. Martin, MD, Carrollton; Jahn A. Patterson, MD, Irvine, Chair; Jahn S. Cave, MD, Henderson; Barbara A. Phillips, MD, Lexington. Not pictured, J. Michael Pulliam, MD, Franklin.

The Morgan Vance, MD Memorial Meeting of the Kentucky Medical Association

**Digest of Proceedings of the Regular Session of the*

House of Delegates

John W. McClellan, MD, Henderson

Speaker of the House

Thomas K. Slabaugh, MD, Lexington

Vice Speaker of the House

Presiding

First Meeting September 15, 1997

John W. McClellan, MD, Speaker of the KMA House of Delegates, called the first Meeting of the 147th Session of the House of Delegates to order at 10:10 am on Monday, September 15, 1997, at the Hyatt Regency Hotel, Louisville, Kentucky. He introduced the Vice Speaker, Thomas K. Slabaugh, MD, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

The invocation was given by Harold L. Bushey, MD, Barbourville. A motion was made, seconded, and carried to approve the Minutes of the 1996 Session of the House of Delegates as published in the December 1996 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:30 AM on Tuesday, September 16, and the President's Luncheon would be held on Wednesday, September 17, at which time the new President would be installed. Dr VonderHaar reminded the delegates that reference committees would convene at 1:00 PM on Monday. He then asked the House members to stand for a moment of silence in memory of KMA members who had died since the 1996 Annual Meeting.

Speaker McClellan announced that each delegate's packet contained a booklet prepared by the Rules Committee outlining the rules the House should follow in its deliberations.

William H. Mitchell, MD, President, presented the Educational Achievement Award to Billy F. Andrews, MD, Louisville. Dr Andrews is Chairman Emeritus, Department of Pediatrics, University of Louisville School of Medicine, and Chief of Staff Emeritus, Department of Pediatrics, Kosair Children's Hospital. Dr Andrews was honored for his many years of innovative work in pediatrics and his dedication to teaching.

Dr McClellan noted that a list of reference committee members serving during the 1997 Annual Meeting had been circulated.

Dr McClellan then called upon Dr Mitchell to give the report of the President. Following Dr Mitchell's report, Ruth Ryan, Immediate Past President

of the KMA Alliance, presented her report. Mrs Ryan indicated that AMA-ERF contributions in Kentucky this year totaled \$62,000, and the appropriate amounts were sent to the University of Kentucky College of Medicine and the University of Louisville School of Medicine. She also reported on other successful projects in which the Alliance had participated.

Dr McClellan introduced the other officers to present their reports. The reports of the President-Elect, Speakers, and Secretary-Treasurer were not read. Harry W. Carlross, MD, Chair of the Board of Trustees, summarized his report. Each of the officers' reports and all committee reports were assigned to a reference committee as noted:

Report Number		Reference Committee
1	Report of the President	A
2	Report of the President, Alliance	A
3	Report of the President-Elect	A
4	Report of the Speakers, House of Delegates	A
5	Report of the Chair, Board of Trustees	A
6	Report of the Secretary-Treasurer	A
7	Report of the Editor	A
8	Report of the Delegates to AMA	A
9	Report of the Executive Vice President	A
10	Report of KMA Physicians Plan, Inc	A
11	Report of the Kentucky Medical Insurance Company	A
12	Report of the EMCK Foundation	A
13	Physician Advisory Committee to Health Kentucky	A
14	Scientific Program Committee	B
15	Scientific Exhibits Committee	B
16	Continuing Medical Education Committee	B
17	Council for Continuing Medical Education	B
18	Cancer Committee	B
19	Physician Workforce Committee	B
20	Organized Medical Staff Section	B
21	Rural Kentucky Medical Scholarship Fund	B
22	Maternal Mortality Study Committee (no report)	C
23	Committee on National Legislative Activities	C
24	Committee on State Legislative Activities	C
25	Committee on Professional Liability Insurance	C
26	Committee on Care of the Elderly	C
27	Public Education Committee	C
28	Committee on Medical Insurance and Prepayment Plans	D
29	PRO Advisory Committee	D
30	Committee to Investigate Changing Trends in Medicine	D

***Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.**



31	Young Physicians Steering Committee	D
32	Resident Physicians Section	D
33	Medical Student Section	D
	KMA Membership Task Force	D
	Ad Hoc Committee on Faculty Membership	D
34	Committee on Maternal and Neonatal Health	E
35	Technical Advisory Committee on Physician Services (Medicaid)	E
36	Committee on Community and Rural Health	E
37	Committee on Physical Education and Medical Aspects of Sports	E
38	Committee on Child and School Health	E
39	Judicial Council	E
40	Interspecialty Council	E
	Ad Hoc Committee to Develop a Comprehensive School Health Education Plan	E

New Business

New Business of the House was assigned to the reference committee indicated:

Resolution	Submitted by	Subject	Reference Committee
101	Estill County Medical Society	Reduction of Tobacco Use While Assuring Community Economic Stability	E
102	Estill County Medical Society	Community Authority for Reduction of Tobacco Use by Children	E
103	Warren County Medical Society	Mandatory HIV Education for Physicians	C
104	Pike County Medical Society	Insulin as a Prescription Drug	B
105	JCMS	KMA Scientific Session Speakers	B
106	JCMS	Dues-Free Membership for Resident Physicians	D
107	JCMS	Shifting of Administrative Burdens by Insurance Companies	D
108	JCMS	Medicare Audits	C
109	Gil Daley, MD	Formation of a KMA Committee to Promote AMA-ERF	A
110	FCMS	Anesthesia	B
111	FCMS	Smoking in Children	E
112	FCMS	Medicaid Funding: KenPAC	A
113	FCMS	Primary Care Management Fee	A
114	FCMS	High School Start Times	D
115	JCMS	Medical Practice Business Expenses	A
116	Francis C. Mappala, MD	Brooks vs. KBML Amicus Brief	A
117	Francis C. Mappala, MD	Revision of KRS 311	A
118	KAFF	Alternative Medical Practice	D
119	JCMS (replaces 114)	Health Carriers' and Managed Care Organizations' Tort Liability	B
120	Warren County Medical Society	Mandatory Domestic Violence Educational Requirements for Primary Care Physicians	C
121	Floyd County Medical Society	KMA International Medical Graduates (IMG) Section	B
122	Suvas G. Desai, MD	Training Requirements for Medical Licensure	B
123	Kentucky Psychiatric Association	Parity for Mental Illness in Medical Benefits Programs	D
124	Estill County Medical Society	Kentucky Forest Stewardship Act	A
125	Estill County Medical Society	Commercial Poultry and Swine Industry	E
126	Henderson County Medical Society	Mandatory Domestic Violence Education for Primary Care Physicians	C
127	FCMS	Full Licensure for Telemedicine Physicians	A
128	FCMS	Unlicensed Practice	B
129	FCMS	Reaffirmation of Resolution R (1995)	D
130	FCMS	Phen-Fen Prescriptions	E
131	Board of Trustees	Physician Participation in Capital Punishment	C
132	Board of Trustees	Fraud and Abuse	C
133	Board of Trustees	Gag Clauses	C
134	Board of Trustees	Mandatory Provisions in Health Insurance Policies	D
135	Board of Trustees	Sale of Tobacco	E
136	Board of Trustees	Tobacco Settlement	E

Dr McClellan then turned the meeting over to Vice Speaker Slabaugh, who indicated that the House had received some late resolutions, the last of which was numbered 97-136. Two new "tribute" resolutions were introduced by the Board of Trustees. The first was entitled "Tribute to Steven Z. Smith, MD," and the second, "Tribute to Milton F. Miller, MD." Both of these physicians were being recognized for their long and distinguished service to the profession, the Association, and the Editorial Board of the *Journal of the Kentucky Medical Association*. The resolutions were read, and a motion was made, seconded, and carried to adopt each as written.

Tribute to Stephen Z. Smith, MD Board of Trustees

WHEREAS, Stephen Z. Smith, MD, has served as Assistant Scientific Editor to the *Journal of the Kentucky Medical Association* with great distinction; and WHEREAS, Doctor Smith has been a member of the Board of Editors for 20 years; and

WHEREAS, the *Journal of the Kentucky Medical Association* has brought credit to this Association for its creativity and outstanding scientific presentations; and

WHEREAS, the *Journal of the Kentucky Medical Association* has received numerous awards while Doctor Smith has served as a member of the Board; now, therefore, be it

RESOLVED, that the 1997 Kentucky Medical Association House of Delegates recognizes Stephen Z. Smith, MD, for outstanding accomplishments; and be it further

RESOLVED, that a framed copy of this resolution be presented to Stephen Z. Smith, MD, for his devotion and outstanding efforts to improve the scientific and medical knowledge of Kentucky physicians.

Tribute to Milton F. Miller, MD Board of Trustees

WHEREAS, Milton F. Miller, MD, has served as Assistant Editor of the *Journal of the Kentucky Medical Association*; and

WHEREAS, Doctor Miller has served with distinction on the Editorial Board of the *Journal of the Kentucky Medical Association* for twenty years; and

WHEREAS, the *Journal of the Kentucky Medical Association* has received numerous awards while Doctor Miller has served as a member of the Board; and

WHEREAS, Milton F. Miller, MD, has been widely acclaimed by several publications which have reprinted several of his fine editorials; now, therefore, be it

RESOLVED, that the 1997 Kentucky Medical Association House of Delegates officially recognizes the important contributions of Milton F. Miller, MD, to his profession, his patients, and to this Association; and be it further

RESOLVED, that a framed copy of this resolution be presented to Milton F. Miller, MD.

Dr Slabaugh also presented to the members of the House a proposed amendment to the Constitution and Bylaws which would allow the Dean of the University of Kentucky College of Medicine and the Dean of the University of Louisville School of Medicine to have designated delegate status in the House of Delegates with voting privileges, as well as provide for representation from the Resident Physician's Section, the Medical Student Section, and the Organized Medical Staff Section of the KMA. It was noted that as an amendment to the Constitution, the proposal was being presented to the House of Delegates this year, would be distributed to each county medical society at least two months prior to the 1998 KMA House of Delegates, and must be approved by the 1998 House by a two-thirds vote.

Speaker McClellan introduced AMA President Percy Wootton, MD, who made a presentation to the House of Delegates.

Dr Wootton addressed concerns regarding the relationship between the AMA and Sunbeam. He emphasized that the AMA Board of Trustees never approved the contract, and had asked that this not go forward. He claimed that their only previous warning of such an agreement was a brief statement indicating that AMA's business section was working on a joint venture.

Dr Wootton stated that the original plan had been a good one — AMA would insert its logo and public health information into certain health products and would receive some royalties. However, the company too closely linked the product with AMA, as if the AMA endorsed it. Subsequently, AMA withdrew from the contract, and Sunbeam is suing for \$20 million. The matter is now under litigation.

Dr Wootton promoted the AMA's new program, AMAPP, which is designed to serve as a single source of information on physician credentialing.

Dr Wootton also addressed some of the current health-related issues in Washington. He reported that the AMA would support legislation to curb inappropriate medical practice, but did not wish to legislate medicine issue by issue, and would seek to protect the physician's right to use medical judgment. Dr Wootton reported that, citing Medicare cuts, Congress established a commission to examine Medicare, and AMA hopes to have representation on this commission.

He then cited perceived gains and losses for medicine under the budget bill. He noted there would be a health initiative for children's medical care, and expanded payment for prevention. However, he noted disadvantages for the dual eligibility patient. Dr Wootton cited increased choice for Medicare patients, who should be allowed to choose whether to remain in a traditional program or enroll in an HMO. This would include the right to contract with physician-sponsored networks.

He stated that the AMA needs the help of all physicians on a clause which allows patients and physicians to enter into independent contracts outside the Medicare program. He noted that it is now illegal for a doctor to negotiate anything with a Medicare patient. Dr Wootton also stressed the need for physicians to continue their advocacy for their patients.

Vice Speaker Slabaugh announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the Nominating Committee members were announced: P. Bruce Barton, MD, Corbin, Chair; John W. Collins, MD, Lexington; Kathleen C. Harter, MD, Louisville; Rebecca D. Shadowen, MD, Bowling Green; and David J. Zoeller, MD, Elizabethtown.

The Speaker adjourned the First Meeting at 11:35 AM.

Second Meeting September 17, 1997

John W. McClellan, MD, Speaker, House of Delegates, called the Second Meeting of the 1997 Session of the KMA House of Delegates to order at 7:00 PM on Wednesday, September 17, 1997.

Barbara Phillips, MD, Lexington, gave the Invocation, and James Bowles, MD, Madisonville, Chair of the Credentials Committee, reported that a quorum was present.

Dr McClellan explained the composition of the House of Delegates and indicated those who had voting privileges.

Dr Arnold Belker read a special proclamation whereby Mayor Jerry Abramson declared September 17, 1997, "C. Kenneth Peters Day" in Louisville, Kentucky.

Secretary-Treasurer VonderHaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were Alfred Cox, MD, President, Indiana State Medical Association; Ira Godwin, MD, Past President, Medical Society of Virginia; and Su-Pa Kang, MD, President, Ohio State Medical Association. Also recognized was Nancy Kintzel, an AMA Field Services representative. Dr VonderHaar also announced the winners of Exhibit Hall prizes.

It was announced that three new tribute resolutions were introduced by the Board of Trustees. The first was in honor of Danny M. Clark, MD, for his many years of service to the Association as a member of the Board of Trustees, and KMA President from 1995 to 1996. The resolution was read, and a motion was made, seconded, and carried to adopt it as amended. A framed copy of the resolution was presented to Dr Clark, who made brief acceptance remarks.

Tribute to Danny M. Clark, MD Board of Trustees

WHEREAS, Danny M. Clark, MD, has served his medical and civic community with pride not only as a physician, but as a concerned citizen, husband, and father; and

WHEREAS, Danny M. Clark, MD, has served with distinction on the Kentucky Medical Association Board of Trustees for 17 years; and

WHEREAS, Danny M. Clark, MD, has fulfilled with honor and devotion the offices of Trustee of the KMA 12th District, Vice Speaker, and Speaker of the KMA House of Delegates; and

WHEREAS, as a KMA nominee and Governor appointee, Doctor Clark has served on the Kentucky Board of Medical Licensure for many years; and

WHEREAS, Danny M. Clark, MD, served as a member of the Board of Directors of the Kentucky Medical Insurance Company for successive terms; and

WHEREAS, Danny M. Clark, MD, served with outstanding poise and courage as President of the KMA in 1995-96; and

WHEREAS, under President Clark's direction, leadership, and negotiating skills, KMA was successful in obtaining the 1996 Kentucky General Assembly and the Governor of Kentucky's support for repeal of the provider tax, and repeal of onerous sections of HB 250, including the Discount Option Program and the Health Policy Board; and

WHEREAS, the KMA and the Commonwealth of Kentucky settled a lawsuit which returned \$52 million to Kentucky physicians and increased physicians' biennial Medicaid reimbursement by \$52 million; now, therefore, be it

RESOLVED, that the 1997 Kentucky Medical Association House of Delegates recognizes the outstanding leadership and devotion of Danny M. Clark, MD, to his patients and to his chosen profession; and be it further

RESOLVED, that Doctor Clark is especially honored by this House of Delegates for his long and meritorious service and duty to this Association, the KMA House of Delegates, his community, state, nation, peers, and friends; and be it further

RESOLVED, that a framed copy of this resolution be read and presented to Danny M. Clark, MD, at the Second Session of the 1997 House of Delegates; and be it further

RESOLVED, that this resolution honoring Doctor Clark be made a permanent part of the proceedings of this House of Delegates.

The second tribute resolution was in honor of A. Evan Overstreet, MD, who has served on the Editorial Board of the *Journal of the Kentucky Medical Association* for 25 years. The resolution was read, and a motion was made, seconded, and carried to adopt it as written. Dr Overstreet was not present at the meeting. A framed copy will be presented to him at a later date.

Tribute to A. Evan Overstreet, MD Board of Trustees

WHEREAS, A. Evan Overstreet, MD, has served on the Editorial Board of the *Journal of the Kentucky Medical Association* for 25 years; and

WHEREAS, the Editors of the *Journal* meet the second Tuesday on a monthly basis at 7:00 AM to consider scientific papers and other matters relating to the *Journal*; and

WHEREAS, it is estimated that A. Evan Overstreet, MD, has attended over 300 meetings of the Editorial Board; and

WHEREAS, Doctor Overstreet is completing his 20th year as Editor of the *Journal of the Kentucky Medical Association*; and

WHEREAS, under his leadership the *Journal* of KMA is recognized nationally as one of the outstanding state medical journals and has received several national awards; now, therefore, be it

RESOLVED, that A. Evan Overstreet, MD, be commended by the 1997 KMA House of Delegates for outstanding service to the profession and to medical journalism; and be it further

RESOLVED, that a framed copy of this resolution be presented to Doctor Overstreet at the second session of the 1997 KMA House of Delegates along with the esteem of his colleagues and friends.

A third resolution was introduced as a memorial to Mr John Ed McConnell, who was a founding executive with Blue Cross and Blue Shield, and a staunch defender of physician autonomy and private practice, as well as one of Kentucky's major advocates and most vigorous and outspoken supporters of nonprofit, community-owned, or religious hospital systems. This resolution was read, and a motion was made, seconded, and carried to adopt the resolution and present a copy to his family.

Memorial to John Ed McConnell Board of Trustees

WHEREAS, John Ed McConnell joined Kentucky Blue Cross in 1942 as one of its founding Executives and worked with Kentucky Physicians, hospital administrators, community and farming organizations to develop Kentucky Blue Cross and Blue Shield and

WHEREAS, John Ed McConnell served as President of Kentucky Blue



Cross and Blue Shield from 1967-76 with great distinction and was widely known as a man of honor, integrity, and great humor and

WHEREAS, John Ed McConnell was a staunch defender of Physician autonomy, private practice, and was one of Kentucky's major advocates and most vigorous and outspoken supporter of non-profit, community owned, or religious hospital systems and

WHEREAS, this Association bestowed its highest honor, the Distinguished Layperson Award upon Mr McConnell for his service and commitment to our patients and the citizens of Kentucky for over fifty years and

WHEREAS, John Ed McConnell passed from this earth on September 14, 1997 therefore be it

RESOLVED, that this Association expresses its deep regret to his family, friends and colleagues with the passage of this giant of Kentucky's health care industry; and be it further

RESOLVED, that a copy of this Resolution be forwarded to the family of John Ed McConnell along with this Association's recognition of his permanent contribution to this state and nation.

The Speaker then turned the proceedings over to Vice Speaker Slabaugh, who called for the Reference Committee Chairs to present their Reports.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional actions brought by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE A

David J. Zoeller, MD, Elizabethtown, Chair

1. Report of the President
 2. Report of the President, Alliance
 3. Report of the President-Elect
 4. Report of the Speakers, House of Delegates
 5. Report of the Chair, Board of Trustees
 6. Report of the Secretary-Treasurer
 7. Report of the Editor
 8. Report of the Delegates to AMA
 9. Report of the Executive Vice President
 10. Report of KMA Physicians Services, Inc
 11. Report of the Kentucky Medical Insurance Company
 12. Report of the EMCK Foundation
 13. Report of the Physician Advisory Committee to Health Kentucky
- Resolution 109 — Formation of a KMA Committee to Promote AMA-ERF
(Gil Daley, MD, and Maurice Oakley, MD)
- Resolution 112 — Medicaid Funding: KenPAC Primary Care Management Fee
(Fayette County Medical Society)
- Resolution 113 — High School Start Times
(Fayette County Medical Society)
- Resolution 116 — Brooks vs. KBML Amicus Brief
(Francis C. Mappala, MD)
- Resolution 117 — Revision of KRS 311
(Francis C. Mappala, MD)
- Resolution 124 — Kentucky Forest Stewardship Act
(Estill County Medical Society)
- Resolution 127 — Full Licensure for Telemedicine Physicians
(Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee A reviewed the following items and recommends they be filed, by consent of the House, without discussion:

1. Report of the President — filed
2. Report of the President, Alliance — filed
3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
5. Report of the Chair, Board of Trustees — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed

9. Report of the Executive Vice President — filed
10. Report of KMA Physicians Services, Inc — filed
11. Report of the Kentucky Medical Insurance Company — filed
12. Report of the EMCK Foundation — filed

Reference Committee A has reviewed reports 1 through 12 and recommends they be filed by the consent of the House without discussion.

Reference Committee A would like to express its appreciation to the authors of the reports which have been filed for their time and energy expended in preparing these reports for the House of Delegates. We recommend adoption of the consent calendar as a whole.

Report of the President

An advocate is defined as one that defends or maintains a cause or proposal, most commonly on behalf of another. Advocacy, then, is the process of providing that support. My experience in the practice of medicine convinces me that "advocacy" truly defines our role as physicians, as individuals, and as a profession.

The advocacy to which we are obligated requires that we dedicate and direct our support not only to patients, but of patients.

When I began this year as President, I noted that we needed to define our priorities if we were to be effective in our primary goal of good patient care, the essential form of advocacy. As individuals, each of us face this challenge daily. As an association, our obvious responsibilities include educating our patients about the lethality of tobacco use; limiting irresponsible behavior and lifestyle activities such as drug and alcohol abuse; working to resolve unrestrained, unprotected, and reckless motor vehicle operation; working to prevent and provide support for victims of domestic violence; educating our patients about the dangers of sexually transmitted diseases; and maintaining a thoughtful influence on medical training centers to produce competent, caring, and committed physicians. Each of us has some role in all of these efforts. It is gratifying for me to be a part of more comprehensive efforts in these areas by the Association.

This year has reaffirmed to me all the positive things I have felt as a physician about our profession. This reaffirmation has been broadened through the opportunities I have had to visit each part of Kentucky and meet with groups of our members. In these meetings I was able to discuss with you directly the problems, concerns, and successes that KMA and medicine have met. These activities have reinforced to me the view that the many confusing, controversial, and even contradictory changes that face patients and physicians demand that we remain clearly on our course as advocates.

The trust of our patients demands that we continue the excellence of our care in spite of economic and social changes; variables that influence our medical decision-making; and the increasing fragmentation, revision, and modification of our medical care system.

Administratively, we must become more efficient and cost effective. Legislatively, we must continue our focus on patient protection. Clinically, we must continue to maintain those skills that justify the trust of our patients.

These goals remain constant. The result of these trusts is our role as advocates for our patients.

I am honored that you have given me the opportunity to represent you this year. I express my sincerest thanks for this opportunity. I have given my sincerest effort to being your advocate.

William H. Mitchell, MD
President

Report of the President, Alliance

I wish to thank the members of the Kentucky Medical Association Alliance for granting me the honor of serving as their president this past year. It was indeed a privilege to witness their significant accomplishments in health education, community service, and political action. They understand the maxim that the most certain thing in life is change and, with their unity of purpose, talents, and compassion, they have met the challenge and performed remarkable feats.

I read recently that in 1906 when the Dow Jones Industrial Average surged above 100 for the first time, nobody paid attention. The *Wall Street Journal* simply noted the closing level in a table. When Alliance members do what

they do for others, though in a selfless and unassuming manner, I believe the fortunate people whose lives they touch *definitely* do pay attention. It's difficult to fully appreciate the tremendous impact that Alliance programs have in Kentucky and in so many communities across this country.

But as Dr Robert McAfee said when he was President of the AMA: "Just as when you throw a pebble into a pond, the ripples expand beyond our sight, so the impact of what each of us does can expand beyond our imagination."

I'd like to tell you about three of the success stories we celebrated this past year.

We are extremely proud of our Vice-President for AMA-ERF, Carolyn Daley of Perry County, who through her tireless efforts on behalf of medical students, prompted sizable contributions to the AMA Education and Research Foundation, primarily to the Student Assistance Fund. This year, AMA-ERF contributions in Kentucky totaled \$62,000 which represents an 18% increase over last year. The majority of that money went to UK and UL. Last April, Bill Applegate sent checks to Dean Wilson and Dean Kmetz for the appropriate amounts.

Mrs Daley continues striving to reach an endowment level from which scholarships will be granted in the name of the KMA Alliance at the University of Kentucky and the University of Louisville medical schools. Last year she succeeded in getting the endowment funds up to over \$5,000 at UK and almost \$3,500 at UL. The AMA office of ERF has agreed to let the money accumulate until we reach the \$10,000 endowed level at each school.

I would be remiss if I did not give part of the credit to Eloise Meigs of Ashland, Kentucky. She is a human dynamo who is responsible over the past 14 years for Boyd County Alliance's consistently being in the top five counties in the nation in donations to AMA-ERF. Almost half of the \$62,000 contributed in Kentucky last year came from Boyd County. Carolyn Daley and Eloise Meigs firmly believe that AMA-ERF contributions are more than just charitable donations; they are a legacy from one generation of medical professionals to the next and in investment in the health of generations to come.

SMART, an acronym for Students Made Aware Reject Tobacco, is a unique health education, anti-smoking program developed and implemented by two Lexington, Kentucky members who are nurses, living and preaching in the heart of tobacco country! Mary Gus Smith and Ginny Luftman target this program toward middle school students 11 to 14 years old. SMART is an upbeat, interactive presentation that educates teenagers about the physiological, cosmetic, social, and economic effects of smoking and smokeless tobacco use. It wisely contains a critical component, the teaching of refusal skills. Audrey Carter teaches the SMART program in Jefferson County. Next year, she would like to present the lessons in the *primary* grades of the inner-city schools.

The Jefferson County Medical Society Alliance is a major supporter in the areas of fund-raising, holiday food preparation, and service at the Healing Place. This 115-bed, men's homeless shelter in Louisville is an innovative medical and social outreach to the homeless, the hungry, substance abusers, and the impaired. In 1989 the Jefferson County Medical Society Outreach Program, Inc, took title to and began to operate The Healing Place and ever since, Alliance members have consistently given of their time and talents to that home and its affiliates for women and families.

I applaud all of our Alliance members for their hard work. Some other projects I'd like to highlight are:

- Daviess County's unusually generous medical scholarship awards;
- Henderson County's Doctor's Day project honoring physicians;
- Hopkins County's assisting the Mahr Center in screening for breast and colorectal cancer;
- McCracken County's Rock N Bowl event to fund allied medical careers scholarships;
- Northern Kentucky's successful legislative efforts that promise to help shape a brighter future for medicine;
- Pulaski County's annual Health Fair; and
- Warren County's Rummage Sale to benefit a shelter for victims of domestic abuse.

I challenge resourceful Alliance members to continue their commitment to fellowship among physicians' families, education of children and adults toward a healthier lifestyle, preservation of rights through political activity, and enhancement of a positive image of medicine.

I especially wish to express my appreciation to KMA staff members Jean Wayne and Sue Tharp, who through their dedication, efficiency, and good

humor, are responsible to a great degree for the continuity and prosperity of the KMA Alliance. Thanks to Bill Applegate, Don Chasteen, Debbie Best, Diane Maxey, Jeanette Thompson, and all the other staff members who are so gracious and accommodating to members of the KMA Alliance. Thank you, Dr Mitchell and all KMA members for your generous support throughout the year.

**Ruth S. Ryan
President**

Report of the President-Elect

It has been a pleasure and an honor to serve you this year as President-Elect, to take part in the myriad of large and small issues that confront the Association, and to have the opportunity to observe your leadership team in action. KMA has been fortunate in having the invaluable service of President William H. Mitchell, MD; Chairman of the Board Harry W. Carlross, MD; and the other members of the Board of Trustees. My work this year on your behalf has been fascinating and humbling.

As I prepare to assume the office of President, I would like to share some thoughts and observations with you. My first observation about our professional Association, as with most successful efforts, is the vital need for input and participation by all in order to build consensus on critical issues. Any effort as large as the one that KMA undertakes, representing the profession, is composite. It is made of each of its individual members, which simply comes down to the fact that all physicians have a moral obligation to give back to their profession, their peers, their patients, and their communities. This axiom of unity through consensus and work leads me to other thoughts.

As I have acquired years in the medical profession, I have sensed and developed, like most of us, a deep obligation to share the benefits I have received with our newer colleagues and others who haven't yet had the time to acquire the cherished years that I have seen. The obligation that we all have for service and participation has motivated a lot of my thoughts for some time. In earlier work with my home county society, for example, I gave this thought some focus, and this feeling of obligation has not diminished. One of the greatest accomplishments any of us can make is to involve others, and this will be one of my foremost goals in the coming year.

To use — or misuse — a popular phrase, "the future of medicine is now." The medical leaders of tomorrow are needed today, so we need to work today to involve tomorrow's leaders.

We've heard countless studies and reports that affirm the changing demographics of medicine. They are irrefutable and a beacon for all of us to use as guides for the future of our Association. There are more women in medicine than ever before. There are fewer solo and small-group practices than ever before. There are more races, cultures, and creeds represented than ever before. In a word, these categories now describe our profession. While the face of medicine is changing, like mine, with time, the body — our goals and commitments — is not changing. As always, the greatest strength of our profession is its diversity, and that diversity is where we must channel our search for new leaders.

I have already asked some key colleagues to make concerted efforts to identify representatives of all elements of medicine to try to get them to become active. I have called upon the great pool of strength of the members of our Board of Trustees for their help and guidance in this effort, and I have made a personal commitment to expand service and participation among all members.

All of the reports and recommendations that will be presented to the House of Delegates represent a chronicle of our diligent work this year and in the past, but comprise just one chapter in the book of our profession. As we face more and greater challenges than ever before, we need more leaders, and there is no question that every member is capable of that leadership.

It is my privilege to be a part of the able leadership that I observed this year and to serve with all of the people who have so effectively superintended our Association and our profession. With your help, it is my sincere goal to continue this tradition. I pledge my deepest efforts and truly appreciate the honor you have bestowed on me in selecting me for your President.

**C. Kenneth Peters, MD
President-Elect**



Report of the Speakers, House of Delegates

Your Speakers would like to cordially welcome you to the 147th KMA Annual Meeting. We hope that you bring the concerns of your constituents and county medical societies, and we pledge our strongest efforts to see that those concerns are given a forum.

This year we have returned to the traditional Annual Meeting format with our first session on Monday and the following session on Wednesday evening. The change to the original format was undertaken to accommodate the preferences of the members for the House and other attendees at the Annual Meeting. In spite of a survey that indicated a weekend format would be desirable, our experience last year proved otherwise. We hope that our present schedule will be more suitable to the members.

The future of our Association rests with young physicians. We hope that each delegate will urge young physicians in their local areas to become involved with the Association and, again, we will make very effort to see that their areas of interest within KMA are made available to them. Following this theme, your Speakers have continued work to place young physicians, women, and minorities on reference committees, in addition to taking into account geographical representation and previous experience. We encourage any member interested in reference committee service to make their desires known either to your Speakers or to members of the KMA staff so that they can develop a more direct influence in the governing process.

At this year's meeting we are pleased to welcome AMA President Percy Wootton, MD, of Virginia. Dr Wootton has graciously agreed to address the House during the opening session, and we look forward to the information with which he can provide us on the current confrontations the AMA is undertaking on behalf of the profession.

On a personal note, your Speaker is pleased to welcome Thomas K. Slabaugh, MD, who was elected Vice Speaker at last year's meeting. Your Speakers have had opportunities to spend time together on issues of the House, and we both look forward to a productive and fruitful relationship on your behalf.

We appreciate the trust that the members of the House have placed in us by allowing us to serve and look forward to an informative and fruitful meeting. As always, your Speakers will be available to any member throughout the Annual Meeting for consultation, to answer questions, or to receive direction.

John W. McClellan, MD
Speaker, House of Delegates

Thomas K. Slabaugh, MD
Vice Speaker, House of Delegates

Report of the Chair, Board of Trustees

1997 was a busy year for your Board and officers even though it was a nonlegislative year. Your Board and Trustees held five meetings, including one special-called meeting. The Executive Committee met five times and the Legislative Quick Action Committee met twice. In addition, we had numerous conference calls related to various regulatory matters, especially the Medicaid partnerships.

As in recent years, legislative and regulatory issues dominated our lives. The movement of the state toward the development and implementation of Medicaid Regional Partnerships was a major issue at every Board and Executive Committee meeting.

Your officers met twice with Governor Patton, Lt Governor Henry, CHS Secretary Morse, and other administration officials to discuss KMA's position on the regional partnerships. It was the Board's position that the state should not implement partnerships in other regions of the state until experience with the pilot regions indicated that the regional partnership approach was clearly superior to the KenPAC program. Because of the problems Regions 3 and 5 appear to be having with their start-up, that position was reiterated to the administration in a letter to the Governor from President Mitchell in August. While our recommendation was not accepted, the administration has agreed not to put the regions out for bid by commercial HMOs until 1999 to give regions time to set up organizations.

There was some positive news on Medicaid. KMA settled its lawsuit with the Commonwealth earlier this year, and the state repaid physicians the \$52 million inappropriately cut from Medicaid payments in 1994. In addition, the administration agreed to restore \$26 million per year over the following two

years to Medicaid physician fees. Clearly, that settlement would not have occurred were it not for the action of KMA. In addition, the problems physicians are having with UNISYS, the state's third-party administrator for Medicaid, appear to be subsiding for the most part.

KMA membership hit a new high this year. We welcomed a major increase in KMA membership from the physician faculty at the University of Kentucky. Two new task forces were appointed this year to focus on recruitment and retention of faculty physicians and to better assess the needs of all members and nonmembers to better position KMA to respond to those needs.

KMA carefully monitored the special legislative sessions on higher education and workers' compensation and maintained a high degree of preparedness in anticipation of a special session on insurance reform. KMA's focus in any insurance reform efforts will be to support the enactment of strong patient protection legislation. As this report is written, the Governor has not yet called a special session. 1998 will see the Kentucky General Assembly back in regular session, and we expect legislation to be introduced to address professional liability, patient protection, prescription drug abuse, and measures to expand the scope of practice of nonphysician practitioners. If a special session is not called, measures to reform health insurance will also be on the legislative agenda.

Because of recent national legislation and the high profile investigation of a major hospital company, physicians can expect to encounter significant efforts to investigate and prosecute instances of alleged fraud and abuse. The Board authorized publishing articles and sponsoring a series of seminars to advise physicians and their office staff about their rights and responsibilities under these statutes.

KMA sponsored seven seminars on practice management this year with more planned next year. Over 700 physicians and office staff attended. KMA plans to hold a series of prelegislative conferences around the state between the time of the KMA Annual Meeting and the convening of the Kentucky General Assembly in January. We also plan a special legislative day in Frankfort after the Kentucky General Assembly convenes. All KMA members are encouraged to attend.

KMA leadership visited Kentucky's Congressional Delegation in Washington, DC, this spring. Our main issues of discussion were changes in the Medicare payment structure, Medicaid, medical liability, and patient protection. We were successful in meeting with every member of the delegation and their senior staff members.

This report is a brief description of the activities that are undertaken every day on behalf of the membership. Changes in our profession . . . scientifically, professionally, politically, and legislatively . . . seem to occur at warp speed. KMA's goal is to keep physicians informed to maintain the tradition of quality, professionalism, and patient choice and relationships. With a unity of purpose, we can continue to provide the best health care system known today. If we allow others to fragment that unity, or if we allow disunity among ourselves, our ability to stay the course is lost.

A report on the Legal Trust Fund is included annually in the Chair's report. Our income this year was \$79,308 and our expense was \$2,707. The fund's balance as this report was written was \$303,571.

The following summary of the Board meetings is designed to provide a quick review of your Board's activities this year. Routinely, the Board meeting begins on Wednesday night and is completed on Thursday morning. Complete minutes of all Board meetings will be provided to Reference Committee A.

Summary of Board Meetings

First Meeting, September 29, 1996

The KMA Board of Trustees held its reorganizational meeting for the 1996-97 Association year on September 29, 1996. Board Chair Harry W. Carlross, MD, introduced the newly elected members of the Board and the new officers. C. Kenneth Peters, MD, Louisville, was elected President-Elect; Donald R. Stephens, MD, Cynthiana, was reelected Vice President; John W. McClellan, Jr, MD, Henderson, was elected Speaker, House of Delegates; Thomas K. Slabaugh, MD, Lexington, was elected Vice Speaker. Newly elected Trustees were Daniel W. Varga, MD, Louisville, 5th District; John T. Burch, MD, Bowling Green, 6th District; Thomas E. Bunnell, MD, Erlanger, 8th District; Richard A. Stone, MD, Richmond, 11th District; Donald E. Brown, MD, Somerset, 12th District; and Meredith J. Evans, MD, Middlesboro, 15th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1996-97 KMA year. Harry W. Carloss, MD, Paducah, was reelected Chair, Board of Trustees, and Donald R. Neel, MD, Owensboro, was elected Vice Chair. Kenneth R. Hauswald, MD, Ashland, and J. Gregory Cooper, MD, Cynthiana, were named as Trustees-at-Large.

Five physicians were elected by the House of Delegates to serve on the 1997 Nominating Committee. Members elected were: P. Bruce Barton, MD, Corbin, Chair; John W. Collins, MD, Lexington; Kathleen C. Harter, MD, Louisville; Rebecca D. Shadowen, MD, Bowling Green; and David J. Zoeller, MD, Elizabethtown.

Second Meeting, December 18-19, 1996

The KMA Board of Trustees met on December 18-19, 1996, at the KMA Building in Louisville. Reports were given by the President; Secretary-Treasurer; Senior Delegate to the AMA; Alliance President; Chair, KEMPAC Board of Directors; Kentucky Medical Insurance Company; Commissioner for Health Services; and the Kentucky Board of Medical Licensure.

Lt Governor Steve Henry and Secretary John Morse gave presentations focusing on physicians' concerns with UNISYS, Medicaid claims, and the Medicaid Regional Partnerships. A progress report on the Regional Partnerships was presented by the University of Louisville School of Medicine and the University of Kentucky College of Medicine.

Appointments were made to the Task Force on Female Physicians, KMIC Board Nominating Committee, CME Committee, and the Committee on Insurance and Prepayment Plans. In further action, a nomination was submitted to the Governor for appointment to the Athletic Trainers Advisory Committee; and nominees were selected for service on the Kentucky Hospital Association Board of Trustees.

Legal Counsel updated the Board on the incorporation of the KMA Physicians Plan, Inc, and its decision not to pursue being a part of the bid on Kentucky Kare.

Additional reports were given by the Task Force on Comprehensive School Health Education, the Committees on National and State Legislative Activities, the Public Education Committee, the Committee on Medical Insurance and Prepayment Plans, and the Advisory Committee to Health Kentucky.

It was noted that the 1997 Annual Meeting will be held in Louisville September 14-18. The theme for the 1997 meeting is "Patient Advocacy: The Physician's Essential Role."

The next meeting of the KMA Board of Trustees was scheduled for April 16-17, 1997, at the KMA Building.

Third Meeting, April 16-17, 1997

The KMA Board of Trustees met in regular session on April 16-17, 1997, at the KMA Building in Louisville. Board members heard reports from the President; Secretary-Treasurer; Board of Medical Licensure; Chair, KEMPAC Board of Directors; Senior Delegate to the AMA; Chair, KMA Physicians Plan, Inc; Chair, Kentucky Medical Insurance Company Board of Directors; and the Commissioner, Bureau for Health Services.

The Board adopted the budget for fiscal year 1997-98 and renewed the KMA-endorsed Blue Cross and Blue Shield group insurance plan. In further action, the Board approved the nominees for reelection to the KMIC Board of Directors; appointed the Chair of the KMA Physician Advisory Committee to Health Kentucky; appointed additional members to serve on the Membership Task Force; and selected nominees for service on the Kentucky Board of Medical Licensure and on the Drug Management Review Advisory Board.

Additional reports were given by the Laboratory Advisory Committee, the Committee on Community and Rural Health, the Committee on National Legislative Activities, the Committee on State Legislative Activities, the Public Education Committee, the Ad Hoc Committee on Faculty Membership, and the Committee on Physical Education and Medical Aspects of Sports.

It was noted that HIV and Domestic Violence Seminars will be held on Thursday, September 18, during the 1997 KMA Annual Meeting.

The KMA Board of Trustees will hold its next regular meeting on August 6-7, 1997 at the KMA Building.

Fourth Meeting, May 22, 1997

A special called meeting of the KMA Board of Trustees was held on Thursday, May 22, 1997, at the KMA Building in Louisville, to hear a presentation by ACMG, an independent consulting firm, regarding the formation of a statewide

physician organization. Following the presentation, the Board authorized a line of credit for KMAPP to develop a statewide managed care organization.

Fifth Meeting, August 6-7, 1997

The KMA Board of Trustees met in regular session on August 6-7, 1997, at KMA Headquarters in Louisville. The Board members heard routine reports from the President; Secretary-Treasurer; Alliance President; Secretary, KMA Physicians Plan, Inc; Senior Delegate to the AMA; Kentucky Medical Insurance Company; Kentucky Board of Medical Licensure, KEMPAC Board of Directors; and the Commissioner, Bureau for Health Services.

Additional reports were given on activities of the Committees on National and State Legislative Activities, Committee on Medical Insurance and Prepayment Plans, Committee on Service and Participation, and the Committee to Investigate Changing Trends in Medicine.

The Board voted to continue the Legal Trust Fund voluntary assessment at \$25. The KEMPAC Board of Directors and *Journal* Editors were appointed, and a Judicial Council nominee was approved. An amendment to the Constitution to provide delegate slots for the UK and UL medical school deans was approved to present to the 1997 House of Delegates.

Reports were given on the Medicaid Regional Partnerships, membership, and the Annual Meeting; and action was taken on 40 committee reports.

The next three meetings of the Board were announced to be during the KMA Annual Meeting.

Executive Committee

The KMA Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the association and to research and make recommendations to the Board of Trustees on issues of major concern. The Executive Committee is composed of eight officers and trustees, and they met on five occasions this past year. They are truly dedicated physicians.

Quick Action Committee

Four officers comprise the Quick Action Committee, namely the President, President-Elect, Chair of the Board, and Secretary-Treasurer. In addition, during legislative sessions our group also includes the Chair of our State Legislative Activities Committee and the Immediate Past President. The Legislative Quick Action Committee held two meetings with officers of the KHA this year to discuss issues of mutual interest. In today's rapidly changing environment, it is essential that our lines of communication remain open. KHA recently changed its bylaws to provide for a physician member on its Board, and Wally O. Montgomery, MD, Paducah, was named to that post.

Ad Hoc Committees

There were five ad hoc committees of the Board working on projects this year. Detailed reports of the KMA Membership Task Force, the Ad Hoc Committee on Faculty Membership, and the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan appear elsewhere in this book.

The Ad Hoc Committee on Service and Participation, chaired by C. Kenneth Peters, MD, made recommendations on length of service of committee members and chairs. The Board adopted the committee's recommendations.

The Laboratory Advisory Committee to Anthem Blue Cross and Blue Shield, chaired by Baretta R. Casey, MD, was appointed by the Board to consider changes in Anthem Blue Cross and Blue Shield operations that specifically affected physician-operated laboratories. Three issues focused on were covered services provided by physician office labs, the exclusionary effect of reduced reimbursement on secondary or reference level laboratories operating in the state, and what was seen as a growing trend toward mandatory referral of PAP smears to out-of-state labs. Given the volatile state of insurance conditions in the state, it may not be reasonable to expect major resolution to these concerns soon. However, the committee will continue to monitor the situation.

Closing Comments

It has been a true honor to serve as your Board Chair the past two years. It provides a perspective on the Association that too few in the profession can even imagine. It would benefit every member and every nonmember to see the varied and complex attempts of nonphysicians to change medicine from this position. To do so would focus appreciation for the efforts of the Board, officers, committees, members, and staff that do so much for Kentucky physicians. Thank you for the opportunity of serving as your Board Chair.

Harry W. Carloss, MD
Chair



Report of the Secretary-Treasurer

I am privileged to report to you as Secretary-Treasurer of the Association and to provide you with some information on the operations of our organization. Typically, the profession continues to face new, as well as ongoing, challenges, and KMA has worked to keep pace with these challenges.

The committee structure of KMA has continued its work on specifically designated areas and the work of these groups is significant and ongoing. Committees are the backbone of KMA and ensure the constant involvement of the profession with key concerns.

As newly defined issues emerge, the Board of Trustees routinely appoints ad hoc committees to deal with specific issues. This year, ad hoc committees were formed to influence the inclusion of health care components into the overall educational plan of the state's public education system and to consider specific concerns with a commercial insurance company. A specific membership task group was appointed to work on productive representation of various segments of the profession in the membership, and a special group was formed to specifically consider areas of concern of academic physicians. These ad hoc groups are noted to give an indication of KMA's attempt to respond thoughtfully to newly emerging needs.

New variants of conventional issues have also been dealt with this year, including internal revisions to the Medicare program, as well as the formation of a statewide Medicaid managed care plan in which many physicians have been involved. KMA has been heavily involved this year in discussions related to health insurance reform and has expended considerable effort considering KMA's appropriate role in managed care.

Internally, KMA has experienced two significant business issues. The first has been the occupation of the new headquarters office at 4965 US Highway 42. The move to the new quarters was completed in October, and full and final occupation has now been completed. The space is quite attractive, and particularly conducive to the operations needs of KMA. At this new site, sufficient meeting space is available to accommodate the many functions that KMA routinely holds. The offices are arranged so that three separate meeting rooms are available, as well as adequate space for KMA's in-house printing operation, along with necessary staff offices. The Board of Trustees has now held three meetings in the new office, and the layout and facilities are pleasantly adequate, particularly to the needs of the Board, as was planned. I would invite any member to visit the offices at your convenience for a tour.

The second significant business item that occurred this year was the beginning of full direction of KMA's new Executive Vice President, William T. Applegate. Mr Applegate, a KMA employee of 28 years, had previously served as Acting Executive Vice President, and assumed his full duties on January 1. I have known and worked with Bill for many years, and have had the added pleasure this year of working with him as the chief executive officer. Bill has impressed all of the officers and Board in this new capacity with his diligence, innovation, and effective management style. He is a true asset to our organization and, in my opinion, has improved the productivity of KMA in a straightforward, positive manner. Bill has instituted some effective operational revisions, and his value to KMA can only increase in the coming years.

It has been my pleasure this year to not only work with our new chief executive, but also our President, Bill Mitchell; President-Elect Ken Peters; and the Chairman of the Board, Harry Carlross. Each of these are sincere, committed individuals who, along with the Board, have provided valuable stewardship to KMA. It is my pleasure to serve as Secretary-Treasurer, and I value the confidence given me by the House of Delegates in electing me to this position.

William P. VonderHaar, MD
Secretary-Treasurer

Report of the Editor

The *Journal of the Kentucky Medical Association* remains the Association's only means of providing **permanent** reference. This publication belongs to and focuses on Kentucky physicians, and we take pride in maintaining its high standards.

The 7-member Editorial Board contends that a medical publication becomes a trade publication if it does not have a commitment to science and education. This dedicated group ensures the integrity, credibility, and no-nonsense medical journalism that embodies each issue of *The Journal*. The Board met 10 times during 1996, and of the 40 manuscripts reviewed (all

unsolicited), the editors rejected 6 and returned 5 with recommendations for revision, indicating a 72.5% acceptance rate. Some 2400 years ago, Hippocrates said, "An important phase of medicine is the ability to appraise the literature correctly." *The Journal* Board appraises the literature correctly.

The Board constitutes a broad specialty representation — Doctors Daniel W. Varga, Scientific Editor, internal medicine; Stephen Z. Smith, Assistant Scientific Editor, dermatology; and Assistant Editors Kimberly A. Alumbaugh, obstetrics/gynecology; Carolyn D. Burns, pathology; Milton F. Miller, internal medicine; Jaroslav P. Stulc, general surgery; and your Editor's area of expertise is gastroenterology/internal medicine.

It gives me great pleasure to recognize Drs Milton Miller and Steve Smith as they complete 20 years of service as *Journal* Editors. I feel privileged to have had these exemplary editors by my side since 1977, and I sincerely thank them for their many contributions.

In May 1996, continuous scheduling difficulties necessitated the resignation of Assistant Editor Martha Keeney Heyburn, MD, an ophthalmologist who had been a member of the Board since 1986. The Board extends its sincere gratitude for Dr Heyburn's 10 years of commitment and support of *The Journal*. Dr Kimberly Alumbaugh was appointed to fill this vacancy and has stepped into her role with élan.

During 1996, *The Journal* featured 26 original scientific articles representing the efforts of 84 authors and 4 Grand Rounds contributions representing 6 authors. *The Journal* also published a rich variety of socioeconomic information on advancing technology, legal advice, and academic trends; a complete preliminary program for the 1996 Annual Meeting, as well as the entire proceedings of that meeting; several discerning contributions by Book Review Author Stephen Z. Smith, MD; Alliance updates; numerous editorials and letters discussing medical issues of interest to Kentucky physicians; and a plethora of pertinent information in the highly successful monthly section headlined "Monitoring Medicine."

Maintaining the economic health of *The Journal*, while at the same time maintaining a high standard of scientific quality, is a priority. Prudent control of costs is ensuring this maintenance. Local advertising is holding its own, and we continue our efforts to develop innovative approaches to attracting advertising dollars.

The Journal must be a conduit for changes taking place in Kentucky. To this end, I would like to receive more letters to the editor, thereby facilitating a lively exchange of viewpoints and ideas on critical medical topics.

The Editorial Board realizes that we serve at the pleasure of you, our readers, and the Board of Trustees. Thank you for your continued support.

A. Evan Overstreet, MD
Editor

JOURNAL NOTE: This year marks Dr Evan Overstreet's 20th Anniversary as Editor of The Journal. Dr Overstreet joined the Editorial Board in 1972 and was appointed Editor in 1977. The Kentucky Medical Association extends its sincere appreciation for Dr Overstreet's unflagging dedication to this important effort.

Report of the Delegates to AMA

It is a privilege to report on behalf of the Delegates to the American Medical Association to this House of Delegates about our activities. KMA is represented to the AMA House by five Delegates and five Alternate Delegates, each elected by this House. The number of allowed delegates is based on AMA membership in Kentucky. AMA Delegates and Alternates are elected for two-year terms and serve at your pleasure.

Over the years, the delegation has undergone change due to retirement, attrition, and the election of new representatives. However, the group has consistently performed diligently and ably on behalf of KMA and all Kentucky physicians. The AMA House of Delegates meets twice a year for approximately five days at each meeting. Your delegation members attend these meetings, together with other representatives from Kentucky, at the expense of their personal time and activities, but do so willingly and energetically. It is appropriate to acknowledge the Delegates and Alternates, who are: Donald C. Barton, MD, Corbin, Delegate; Wally O. Montgomery, MD, Paducah, Delegate; Robert R. Goodin, MD, Louisville, Delegate; Ardis D. Hoven, MD, Lexington, Delegate; Donald J. Swikert, MD, Florence, Delegate; Bob M. DeWeese, MD, Louisville, Alternate Delegate; J. Gregory Cooper, MD, Cynthiana, Alternate

Delegate; Preston P. Nunnelley, MD, Lexington, Alternate Delegate; William B. Monnig, MD, Edgewood, Alternate Delegate; and Baretta R. Casey, MD, Pikeville, Alternate Delegate.

Even though a small state, your delegation and other members from Kentucky are energetically involved to the point where Kentucky has gained some prominence as a direct result of their participation. Routinely, in addition to Delegates and Alternates, Kentucky physicians representing the Organized Medical Staff Section and the Resident Physicians, Medical Student, and Young Physicians Sections are in attendance. You should know who some of these individuals are. During this past year, in addition to your AMA Delegates and Alternates, you were further represented by William B. Monnig, MD, Edgewood, who is the Secretary of the Governing Council of the AMA Organized Medical Staff Section; Judy Linger, MD, Georgetown, who is a past Chair of the AMA Resident Physicians Section Governing Council; Bruce Scott, MD, Louisville, who is the AMA Young Physicians Section representative to the AMA House; Hoyt D. Gardner, MD, Louisville, Past AMA President; as well as your President and President-Elect, William H. Mitchell, MD, Richmond, and C. Kenneth Peters, MD, Louisville.

As further indication of the prominence of individuals from Kentucky who represent KMA, it should be noted that KMA's recently retired Executive Vice President, Robert G. Cox, was presented with the Citation for Distinguished Service by the AMA House of Delegates; Bryce Schuster, President of the KMA Medical Student Section at the University of Louisville, accepted an award from the AMA on behalf of the KMA-MSS for having recruited the highest number of new members in UL's size category this year; and Drs Casey, Scott, Hoven, and Barton served on reference committees.

Obviously, most members are aware of the service of Robert R. Goodin, MD, on the AMA Council on Continuing Medical Education. Bob Goodin was reelected for a four-year term on this council at the AMA Annual Meeting in June. Bob is a very capable and knowledgeable spokesman for Kentucky and all physicians. In addition, KMA will support the candidacy of Ardis D. Hoven, MD, Lexington, for a position on the AMA Council on Medical Services, and with the endorsement of the KMA Board of Trustees, Bruce Scott, MD, Louisville, is a very strong potential candidate for a position on the AMA Board of Trustees designated for young physicians.

This broad representation by individual Kentucky physicians at the AMA level is very gratifying, as well as very positive for our own Association. This year saw the presentation and defense of three resolutions initiated by the KMA House of Delegates that were submitted to the AMA House of Delegates. These resolutions were: "Pap Smears as Clinical Laboratory Tests," "Pharmaceutical Manufacturers' Link to Managed Care," and "Proper Use of AMA-CPT Codes." Leaning on the expertise of individual Kentucky physicians, your AMA delegation vigorously carried these issues to the AMA House. The resolution on Pap smears has been referred for study by the AMA Board of Trustees to the AMA Council on Scientific Affairs with additional input from several Kentuckians, and will be considered at the next AMA meeting in December. The resolutions on pharmaceutical manufacturers' link to managed care and proper use of AMA-CPT were both adopted by the House of Delegates and are now AMA policy.

Your AMA delegation also attempted to give further accountability of its representation of you by initiating a series of articles in the *KMA Journal* this year. Each Delegate and Alternate is assigned to routine attendance at one of the AMA reference committees. This ongoing assignment allows each of our individual delegation members to become knowledgeable of and experienced with ongoing issues. To help disseminate the information that is regularly dealt with, each member of the delegation has been developing an article for the *KMA Journal* so that the membership can receive more detailed information on some of the issues considered.

At each AMA meeting, the reports and resolutions providing all of the items of business considered by the House constitute between four and five inches' depth of paper. It is virtually impossible to provide any sort of concise summary on these issues routinely. It is hoped that the *Journal* articles and other contacts that members of the delegation have with various segments of the membership will give some idea of the breadth of involvement of the AMA. All issues considered by the AMA House are separated into nine major areas, which are: Constitution and Bylaws/ethics, medical service, legislation, medical education, public health, science and technology, organizational issues, medical practice/facilities, and health care data systems. You are encouraged to seek out any member of the delegation for questions or

comments you may have about AMA activities.

On behalf of the AMA delegation, I would like to express my sincere thanks for the trust given to us in representing you and for the opportunity to serve.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

Over the years, KMA has been blessed with outstanding physician leadership and this year was no exception. President Mitchell attended countless meetings representing KMA. He was constantly and immediately available to staff and his analytical approach to issues resulted in well thought out, well reasoned decisions throughout the year. He is always informed and prepared, and it was a pleasure for staff to work with him.

Harry Carlross, MD, completed a second exemplary year as Chair of the Board of Trustees. He is politically astute, and approached every issue from the point of view of what was best for the KMA membership. Serving as Chair of a Board of 32 independent thinkers is no easy task; but he handled the job with fairness and objectivity, and some might say, with great patience.

President-Elect Kenneth Peters, MD, hit the ground running, with a number of ideas for improving the participation of young physicians and others who have not yet had the opportunity to serve the Association. We look forward to assisting him reach those goals over the next year.

I can't say enough about the expertise, time, and energy given KMA by Secretary-Treasurer VonderHaar. Dr VonderHaar is at the KMA office almost as often as we are and his commitment to KMA and his profession are without peer. Staff is grateful for his availability and support.

Richard Hench, MD, completed his eighth year as Budget Committee Chair. KMA is in excellent financial condition due in large part to the leadership and guidance Dr Hench has provided during his tenure.

State Legislative Chair Wally O. Montgomery, MD, continues his dedicated service to KMA, maintaining daily contact with KMA's legislative staff during the two special sessions held this year and as KMA prepares for the regular session in January 1998.

Danny M. Clark, MD, leaves the Board this year after 17 years of service to KMA. His contributions include serving as Trustee, Vice Speaker and Speaker of the House of Delegates, and President of KMA. He serves on the Kentucky Board of Medical Licensure, and the Boards of KMIC and KMA Physicians Plan, Inc. Dr Clark has served KMA and his profession with distinction, and his wisdom and participation will be missed.

It is an honor and privilege to have been selected to follow Mr Joseph P. Sanford and Mr Robert G. Cox as KMA's third Executive Vice President. Both of these gentlemen set high standards for themselves and staff which all of us constantly strive to meet. I am proud to be associated with a fine group of ladies and gentlemen that work hard every day to represent the best interests of Kentucky physicians.

The support, leadership, hard work, and commitment of the Board of Trustees and KMA members made the transition to my new role possible with a minimum of anxiety. I am grateful for your support and confidence.

I ran across an old "Ziggy" cartoon recently. Ziggy was sitting on a rock, looking very pensive, and the caption read, "I miss the good old days. Things were much more like they used to be back then." A review of the House of Delegates in the "good old days" of 1968, the year I joined the KMA staff, yielded discussions on moving the then two-year-old Medicaid program to a true insurance program and requiring that it pay usual, customary, and reasonable fees, similar to those just developed and implemented by Blue Cross and Blue Shield. Medicaid and Medicare were only three years old, and Comprehensive Health Planning was the latest government panacea. Then KMA President, George Brockman, MD, prophetically stated that "over the short term, neither we nor government are going to be able to significantly influence the rising total health care costs." Twenty-nine years later, health cost remains the driving issue in health care.

The challenges faced by KMA, our sister state medical associations, and the American Medical Association over those twenty-nine years have been significant. But one thing remains clear. Organized medicine met the challenges head on, and to the best of its abilities, protected the best interests of the patient, the profession, and the public. It accomplished its objectives with one of the most potent forces known — the volunteer.



It's been said that the success of an organization is the result of a synergy from volunteers (members) and staff. The most effective organizations maximize the contributions of both. The physicians who volunteer their time and effort on behalf of KMA, their fellow physicians, and their patients, are the heart and soul of KMA. Without them the organization would not exist, nor would it enjoy the success it has achieved since its organization in 1851.

Perhaps the finest example of that effort occurred over the past three years. KMA leadership, county societies, the general membership, the KMA Alliance, and staff synergy resulted in the restoration of \$104 million in Medicaid physician fees over a three-year period. The provider tax on physicians is being phased out. Onerous provisions of HB 250 which established a five-person board with almost unlimited authority over the entire health care section, including physicians, was repealed. These results clearly demonstrate the influence and power the profession can bring to bear when necessary.

KMA active membership is up over 300 members this year, a record gain of 8%. Faculty physicians at the University of Kentucky increased their membership position dramatically, and efforts are underway to better develop and implement activities faculty members have identified as important based on responses to a faculty survey done by the Ad Hoc Committee on Faculty Physicians. We are deeply appreciative of University of Kentucky Dean Emery Wilson, MD, and University of Louisville Dean Donald Kmetz, MD, for their strong support of KMA and its activities.

A special Task Force on Membership has also been appointed, ably chaired by Ardis Hoven, MD; and a number of promising approaches have been identified. Preston Nunnelle, MD, chairs an Ad Hoc Committee on Faculty Membership which is working to identify issues of importance to faculty members. KMA has a diverse membership, and actions are underway to encourage more involvement by all segments of the membership.

Medicaid managed care and the development of regional partnerships are areas of major concern for KMA. Leadership met with Governor Patton, Lt Governor Henry, CHS Secretary Morse, and other administration officials on two occasions. We asked the Governor to delay extending the regional partnerships until the pilot projects in Fayette and Jefferson counties clearly demonstrate they are superior to the KenPAC program. The Governor, citing the impact of budgetary pressures, was cordial but respectfully declined KMA's request. The administration did agree to delay any effort to put Medicaid contracts out to bid by commercial third parties until 1999 to give regions time to develop local partnerships.

Managed care or, more accurately, redirecting resources, was a concept born in the HMO movement of the early 1970s. It has expanded to the point where approximately 68% of Kentucky's population is covered by some form of managed care. That number will grow as more of the state's 500,000+ Medicaid recipients are placed into HMOs. The Medicare population has only a slight penetration by managed care but it will grow as today's workers, who are often covered by managed care plans now, retire and become eligible for Medicare.

KMA Physicians Plan, Inc was authorized by the House of Delegates last year and asked to establish a physician-owned and operated multiprovider managed care organization. That task has been formidable. A significant part of the past year was spent in search of a consultant who could take our idea and make it a reality. The search and selection process utilized a significant amount of staff and volunteer physician time, mostly provided by KMAPP Board Chair, Robert R. Goodin, MD. Unfortunately, after negotiating with what we felt would be a satisfactory management firm, discussions were discontinued because of an unresolvable conflict on the part of the consultant. As a result, the search process had to be reinitiated.

During this period, the insurance and managed care environment in Kentucky underwent changes. A growing number of local and regional managed care organizations either owned by physicians or with significant physician participation may affect the necessity and desirability of a KMA-sponsored statewide network. Studies are underway by KMAPP to determine the true potential for such an undertaking before committing additional KMA resources.

In the meantime, KMA continues to offer a series of programs on managed care, practice management, and other timely issues for the membership. The KMA Annual Meeting offers 16.5 hours of Category 1 CME... free. We are exploring telemedicine as a mechanism to bring these programs into all areas of Kentucky and committees are reviewing other communication tools, such as the Internet, as a means of furnishing CME. As you recall, this is the major purpose for which KMA was founded.

Today's rapidly changing environment also presents challenges to staff as we strive to maintain an appropriate level of service to the membership and help physicians prepare for the future. Meeting the needs of today and preserving those traditions which have made American medicine the world leader in health care is a priority within KMA. Thanks to the Board of Trustees, the Executive Committee, and the Budget Committee, we have been allowed to purchase modern office equipment and technology. In turn, this has permitted us to be innovative in providing support and enhances our overall staff performance and ability to communicate effectively with membership. In October of 1996, KMA's Headquarters Office moved to a new location on Brownsboro Road that has greatly expanded our ability to better serve the membership and the activities of KMA's volunteer committees and Board. We have the capacity to hold several meetings at our office site that were previously scheduled elsewhere due to space constraints.

Don Chasteen, KMA's Director of Public and Governmental Relations, celebrated his twentieth anniversary with KMA this year. Don's wide range of talents are a vital part of the staff organization. Pat Padgett joined the staff this year as Director of Socioeconomic Affairs and Staff Counsel. Pat is a quick learner and a hard worker, and has proven to be a great asset to staff.

I have been privileged to be a member of KMA's fine staff. You won't find a more dedicated, loyal, or hard working group of individuals anywhere. They do whatever it takes to get the job done and we appreciate their efforts.

The future of medicine holds many challenges; but with KMA's tradition of excellent physician leadership, a strong and active membership, an experienced and motivated staff, I believed we will find many opportunities as well.

William T. Applegate
Executive Vice President

KMA Physicians Plan, Inc

This is a report regarding the activities of the KMA Physicians Plan, Inc. The former Physician Organization Study Committee, which was established by KMA in 1993, met with representatives of National Health Services (NHS) on September 17, 1996, in an effort to obtain a state contract to provide health care services to the Kentucky Kare program, which is the state's self-insured health plan. NHS proposed the idea of KMA providing a statewide physician network to the Kentucky Kare PPO. At the time the representatives from NHS met with the committee, it was the impression of all concerned that Kentucky Kare would set forth a request for proposal that would allow for a physician network.

In anticipation of a statewide network being formed, the KMA House of Delegates passed a resolution which stated the following:

Resolved, the KMA proceed as indicated in a timely fashion to form a managed care organization which would maintain and operate a physician-owned and controlled network of physicians open to KMA members, who in cooperation with other health care providers, would contract for and deliver managed health care services. The network will provide high quality medical care that is cost-competitive with other efficiently operated managed care plans in a manner that does not intrude on the medical judgment of physicians or interfere with the physician-patient relationship.

Pursuant to this directive by the House of Delegates, a legal entity was formed as a for-profit subsidiary of KMA and was named KMA Physicians Plan, Inc. The KMA Board of Trustees appointed physicians from all areas of the state to serve as KMAPP Board members. The KMAPP Board met on three formal occasions throughout the year.

At the Board's first meeting, the following officers were elected: Robert R. Goodin, MD, Chair; James R. Bean, MD, Vice Chair; Danny M. Clark, MD, Secretary; and Daniel W. Varga, MD, Treasurer. At that meeting, the Board was provided details of a proposed agreement between National Health Services and KMAPP to provide services to the Kentucky Kare program. The proposal by NHS was structured so that KMAPP would serve as a subcontractor to NHS, which would then serve as the prime contractor and assemble the provider groups necessary to meet the requirements outlined in the Kentucky Kare RFP. Following a presentation of employees of NHS, as well as a lengthy discussion of the proposal, the Board rejected the proposal. This rejection was in part due to changes in ownership of NHS, as well as the fact that the deadline for submitting a response to the Kentucky Kare RFP came too soon for the network to be assembled in a timely manner.

It was decided that the Board should look into the possibility of forming

a statewide provider network. In an effort to explore the formation of the network, Dr Goodin and other members of KMA staff visited the South Carolina Medical Society, which had established a statewide provider network. After visiting the South Carolina Medical Society, the Board received and reviewed a proposal from ACMG, Inc to develop a statewide provider network. ACMG had already developed similar networks in South Carolina and Mississippi. ACMG made a formal proposal to the KMAPP Board and the Board approved the idea of developing a network with ACMG, as long as a feasible contract could be negotiated.

For the next several weeks, Dr Goodin, KMA staff, and Charles J. Cronan, IV, Legal Counsel, conducted negotiations with ACMG. When it was thought that an agreement could be reached with ACMG, a special meeting of the KMA Board of Trustees was called to approve funding for the project. After a presentation by ACMG, the Board of Trustees approved funding for the project and the KMAPP Board met to approve certain terms and conditions for the establishment of the network.

Over the next several weeks, however, it became apparent that ACMG could not develop a statewide provider network and financial terms could not be reached. For these reasons, negotiation with ACMG were terminated.

KMAPP continues to explore the formation of a statewide provider network. Consultants are still making proposals to assist KMAPP in establishing the network and information continues to be gathered in the hope that the formation of a network can become a reality.

KMAPP is a wholly-owned, for-profit subsidiary of the Kentucky Medical Association. This report is made for information purposes only.

Robert R. Goodin, MD
Chair

Report of the Kentucky Medical Insurance Company

Kentucky Medical Insurance Company's performance in 1997 has been outstanding. By midyear, KMIC insured 1,841 physicians in Kentucky and surrounding states. Renewals for 1997 are at 93%. Total policyholders, including facilities and workers' compensation business, have reached a high of 2,799. Much of this growth has been in the area of workers' compensation. As of midyear 1997, KMIC has written 403 workers' compensation policies.

Highlights

These positive numbers translate into growth in premiums. So far in 1997, premiums are up 22%. Premiums written were \$16.3 million for the first six months of 1997, compared to \$13.4 million for the same period in 1996.

Shareholders' equity at June 30, 1997, was \$27.9 million, up 3% compared to December 31, 1996.

Assets stood at \$98.1 million as of June 30, 1997, and net income was \$517,000 for the same period.

Marketing

KMIC's A- (excellent) rating was reaffirmed in June. At the same time, KMIC's parent company, Michigan Physicians Mutual Liability Company, was upgraded by A.M. Best from a B++ rating to an A- (excellent).

KMIC remains the market leader in Kentucky. Furthermore, 81% of the company's premiums come from Kentucky policies.

Ohio continues to be a growth market for KMIC. As of June 30, 1997, premiums stood at \$2.6 million, up 73% over the same period in 1996.

The current Ohio market is very volatile, creating a marketing opportunity. PIE Mutual, the leading writer in Ohio, and The Doctors' Company have signed a letter of intent. It provides for the joint formation of a managing general underwriter (MGU) in Ohio. The MGU will operate as a vehicle for the transfer of PIE insured physicians to The Doctors' Company at the time of policy renewal.

Claims

	As of June 30	
	1997	1996
Claims opened	231*	146
Claims Closed:		
with payment	21	41
without payment	105	97
	126	138
Net Indemnity Paid	\$875,082	\$3,722,506
	<u>Tried</u>	<u>Won</u>
1997 trial record as of 6/3/97:	22	15

*Ohio tort reform resulted in an inordinate number of filings prior to its effective date.

Risk Management

The KMIC Risk Management Department is participating in the Physicians Insurer Association of America's (PIAA) Close Claims Data Sharing project. To date, 42 of KMIC's closed claims (closed in 1997) have been submitted. The data will be compiled with that of other PIAA companies to allow KMIC to obtain reports for loss prevention research.

The Risk Management Department is also participating in a committee organized by the Kentucky Cancer Program. Other committee members include representatives from the American Cancer Society, the Kentucky Department for Public Health, and the Kentucky Academy of Family Physicians. This committee has been brought together to plan a primary care provider program to increase breast and cervical cancer screening in Kentucky.

Other

KMIC's parent company, Michigan Physicians Mutual Liability Company (MPMLC), has merged with New Mexico Physicians Mutual Liability Company (NMPMLC), effective August 1, 1997. New Mexico Physicians Mutual is a market leader in New Mexico and is physician-focused and owned. Like KMIC and MPMLC, New Mexico Physicians Mutual has a passion for aggressive claims defense and is dedicated to serving the health care market *long term*. MPMLC and its subsidiaries now have offices in Albuquerque, Chicago, Columbus, East Lansing, Indianapolis, Louisville, and Minneapolis.

Within the next few weeks, MPMLC is going online with its own Web site. KMIC will be prominently featured on the site. The online address is www.mpmlc.com.

Richard F. Hench, MD
Chair

Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc

The Ephraim McDowell Cambus-Kenneth Foundation was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation and exists exclusively for "charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance."

The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from Mr Joe A. Wallace and Mrs Cecil Dulin Wallace, upon their deaths, the 550-acre Cambus-Kenneth Farm located in Danville. As many of you know, Mr Wallace passed away in late 1992. Today, the Farm remains with Mrs Wallace, recipient of the 1993 KMA Award. The Cambus-Kenneth Farm was owned at one time by the pioneer physician, Ephraim McDowell, MD; served as his summer home; and was the site of his death. Pursuant to the bylaws of the Corporation, the current officers of KMA were appointed as officers of the Foundation in September, 1996.

William H. Mitchell, MD
President

END OF CONSENT CALENDAR ITEMS

Report of the Physician Advisory Committee to Health Kentucky (Health Care Access Foundation)

The Physician Advisory Committee to Health Kentucky has overall responsibility for monitoring and guiding the referral system to the Health Care Access Foundation Program. Members of the operational committee also serve as a medical advisory group on questions that may arise during the course of the program's operations.

The Kentucky Physicians Care Program, which is the physician element of Health Kentucky, provides access to nonemergency health care to uninsured Kentuckians with incomes at or below 100% of the federal poverty level at no cost to the patient.

Originally, the Kentucky Physicians Care Program offered only physician and hospital services. Now, at no cost, pharmaceutical products, dental care, hospice, and home health care services are also available. This year over 1,700 physicians are participating in the program, and over 154,000 needy individuals are certified for eligibility.

In addition to physician participation, there are 100 participating



hospitals, 304 participating dentists, and 431 participating pharmacists. An unknown quantity of free home health care and hospice services have also been provided through this program.

This year the advisory committee met with Secretary of the Cabinet for Health Services, John Morse, who has an interest in expanding access to health care to indigent patients, particularly those ineligible for Medicaid. As an inducement to physicians to participate in indigent care programs, the Secretary noted that Senate Bill 400, passed during the 1996 Kentucky General Assembly, may provide professional liability relief to physicians who are defined as "charitable health care providers." Ideally, he would like to establish some sort of integrated network across the state that encompasses all providers and modes of indigent care. Although no such recommendations were made to increase the participation in the Kentucky Physicians Care Program, Secretary Morse asked for KMA's support for expanding indigent care, administratively and legislatively.

In an effort to expand physician participation, targeted letters were sent to physicians in each KMA trustee district and thought was given to the use of public service announcements to persuade physicians to increase participation levels.

It was noted that Health Kentucky and the Good Samaritan Foundation were conducting a joint research project to review patient and provider satisfaction levels with the program, to seek alternatives to the provision of indigent care, and try to detect any abuse of the system. Outcomes from this study should provide information to participating providers and help to improve health care delivery to Kentucky's indigent.

As in the past, the committee continues to believe that the program is worthwhile and serves a useful purpose providing a conduit for individuals to primary physician services. For that reason, the committee recommends:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
 - a) Program funding being continued, as appropriate, by Health Kentucky.
 - b) A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
 - c) The other participating provider groups maintaining the same or increased level of participation in the foundation program.
 - d) Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
 - e) Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

I appreciate the continued interest and participation of the members of the Advisory Committee and am most grateful for the generosity of the physicians in this state who continue to give so generously and freely of their services.

Donald C. Barton, MD
Chair

RECOMMENDATIONS:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
 - a) Program funding being continued, as appropriate, by Health Kentucky.
 - b) A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
 - c) The other participating provider groups maintaining the same or increased level of participation in the foundation program.
 - d) Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
 - e) Health Kentucky making documented efforts to make Kentucky

legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Mr Speaker, Reference Committee A also recommends adoption of Report 13 and its Recommendations pertaining to participants in Kentucky Physicians Care.

RESOLUTION 97-109

Formation of a KMA Committee to Promote AMA-ERF

Gil Daley, MD, Perry County

Maurice Oakley, MD, Boyd County

WHEREAS, the American Medical Association Education and Research Foundation (AMA-ERF) supports the education of our future physicians and funds research projects in our medical schools; and

WHEREAS, our Kentucky physicians recognize the need to educate our physician families about the importance of giving to AMA-ERF; and

WHEREAS, many of our physicians do not know about AMA-ERF and how to contribute; and

WHEREAS, the AMA Alliance (Auxiliary) raises over 92% of the funds for AMA-ERF; and

WHEREAS, any contributions to AMA-ERF, personally endowed scholarships to medical schools, and/or sharing card contributions can be given through the Kentucky Medical Association Alliance (Auxiliary); now, therefore, be it

RESOLVED, that the Kentucky Medical Association appoint an AMA-ERF committee; and be it further

RESOLVED, that the Kentucky Medical Association encourage physicians and their families to support the American Medical Association Education and Research Foundation by contributing to the medical school of their choice through AMA-ERF.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A heard testimony on Resolution 109, Formation of a KMA Committee to Promote the AMA-ERF, submitted by Doctor Gil Daley of Perry County and Doctor Maurice Oakley of Boyd County.

After discussion, the reference committee recommended that Resolution 109 be amended by deleting the first Resolved.

Reference Committee A recommends adoption of Resolution 109 as amended.

RESOLUTION 97-112

Medicaid Funding: KenPAC Primary Care Management Fee

Fayette County Medical Society

WHEREAS, historical funding of the Kentucky Medicaid program under the HCFA Section 1915b Medicaid waiver KenPAC (Kentucky Patient Access and Care) program has included a \$3 per patient, per month, management fee for AFDC and AFDC-related Medicaid recipients since 1985; and

WHEREAS, the management fee compensates primary care physicians for additional time, effort, expense, and expertise necessary to perform and oversee case management for assigned Medicaid recipients; and

WHEREAS, KenPAC recipients will be transitioned into Kentucky's Section 1115 Medicaid waiver regional managed care program and the KenPAC program terminated in each region as the 1115 waiver program is implemented; and

WHEREAS, Medicaid mandatory managed care under Kentucky's 1115 waiver will include Medicaid recipient assignment to a primary care case manager ("gatekeeper") and require expanded patient care management responsibilities for primary care physicians; and

WHEREAS, all Medicaid recipients, including ABD-eligible (Aged, Blind, Disabled), will be assigned to a primary care case manager under the 1115 waiver, increasing the case complexity and the primary care physician's responsibility and effort; and

WHEREAS, the formula for funding of the new 1115 Medicaid waiver program must take into account historical funding of Kentucky's Medicaid

program and actuarial projection of future equivalent funding; and

WHEREAS, historical funding includes the KenPAC primary care \$3/month case management fee; and

WHEREAS, the Kentucky Department of Medicaid has deleted the KenPAC primary care case management fee from funding of the 1115 waiver capitation payment in order to cut costs; and

WHEREAS, primary care physicians will be unfairly penalized by elimination of the traditional case management fee; and

WHEREAS, participation of primary care physicians in the regional Section 1115 waiver Medicaid managed care programs and provider partnership arrangements will fall, losing vital and sometimes scarce primary care physician participation; now, therefore, be it

RESOLVED, that the KMA vigorously petition John Morse, Secretary of the Cabinet for Human Resources, and Commissioner of the Department of Medicaid; Governor Paul Patton; and the Kentucky legislature, as necessary, to restore historical funding of the KenPAC monthly case management fee to the Department of Medicaid actuarial calculation of the Section 1115 waiver regional monthly capitation payment for managed care of Medicaid recipients.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A heard testimony on Resolution 112, Medicaid Funding: KenPAC Primary Care Management Fee, submitted by the Fayette County Medical Society. The reference committee recommends the Resolved be amended to read:

RESOLVED, that the KMA vigorously petition John Morse, the Secretary of the Cabinet for Human Resources Health Services, and Commissioner of the Department of Medicaid; the Governor Paul Patton; and the Kentucky legislature, as necessary, to restore historical funding of the KenPAC monthly case management fee to the Department of Medicaid actuarial calculation of the Section 1115 waiver regional monthly capitation payment for managed care of Medicaid recipients.

Mr Speaker, Reference Committee A recommends adopting Resolution 112 as amended.

RESOLUTION 97-113

High School Start Times Fayette County Medical Society

WHEREAS, research indicates that many adolescents need nine or more hours of sleep per night; and

WHEREAS, research indicates that circadian rhythm changes occur in adolescents, leading to a "phase delay" in natural sleep onset and waking times; and

WHEREAS, data indicates that adolescents who are unsupervised in the afternoon have increased rates of depression and pregnancy; and

WHEREAS, high school start times earlier than 8:00 AM are associated with reduced sleep time in high school students; and

WHEREAS, inadequate sleep in adolescents is associated with poorer health and academic performance; now, therefore, be it

RESOLVED, that the Kentucky Medical Association ask the Committee on Child and School Health to evaluate the impact of early high school start times on health and education in Kentucky.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Testimony was heard on Resolution 113, entitled High School Start Times submitted by Fayette County Medical Society.

Reference Committee A recommends that Resolution 113 be amended by deleting the phrase "to evaluate the impact of early high school start times on health and education in Kentucky" to replacing it with "to place on its agenda the issue of the impact of early high school start times on health and education in Kentucky for discussion and recommendations." The Resolved would then read:

RESOLVED, that the Kentucky Medical Association ask the Committee on Child and School Health to place on its agenda the issue of the impact of early high school start times on health and education in Kentucky for discussion and recommendations.

Reference Committee A recommends adopting Resolution 113 as amended.

RESOLUTION 97-116

Brooks vs KBML Amicus Brief Francis C. Mappala, MD

WHEREAS, the Middlesboro ARH Medical Staff Executive Committee on August 20, 1997, resolved to file an amicus brief in *Brooks vs. KBML, et al*, upholding the legal duty for physician members of the Kentucky Board of Medical Licensure (KBML) to be honest with other physicians in the state of Kentucky; and

WHEREAS, Section II of the AMA Code of Ethics sets forth a physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception; and

WHEREAS, all members of the KMA are required to abide by the AMA Code of Ethics; and

WHEREAS, the Kentucky Court of Appeals has recently held there is no duty of the KBML to disclose the truth, as set forth in the KBML minutes, to physicians whose conduct may be reviewed; now, therefore, be it

RESOLVED, that KMA file an amicus brief in the case of *Brooks vs KBML, et al*, supporting the legal duty of physician members of the KBML to be honest with all other Kentucky physicians in any and all matters which may relate to the practice of medicine. This legal duty is based upon KRS 311.597(4), which incorporates by reference the Principles of Medical Ethics of the AMA.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next heard testimony on Resolution 116, Brooks vs. KBML Amicus Brief, submitted by Francis C. Mappala, MD. A majority of Reference Committee A recommend that Resolution 116 be rejected.

Two members of the reference committee disagreed with the majority and filed a minority report, which is attached.

MINORITY REPORT OF REFERENCE COMMITTEE A

Resolution 116 — Brooks vs KBML Amicus Brief (Francis C. Mappala, MD)

A minority report, filed by Susan Bornstein, MD, and Joseph Dobner, MD recommends that the Resolved be amended to read:

RESOLVED, that KMA file an amicus brief in the case of Brooks vs. KBML, et al supporting supports the legal duty of physician members of the KBML to be honest with all other Kentucky physicians in any and all matters which may relate to the practice of medicine. This legal duty is based on KRS 311.597(4), which incorporates by reference the Principles of Medical Ethics of the AMA.

The minority of Reference Committee A recommends that Resolution 116 be adopted as amended.

Respectfully Submitted,
Susan G. Bornstein, MD, Louisville
Joseph J. Dobner, MD, Frankfort

The Minority report was rejected. The majority recommendation to reject Resolution 97-116 was approved. Resolution 97-116 was rejected.

RESOLUTION 97-117

Revision of KRS 311 Francis C. Mappala, MD

WHEREAS, the Middlesboro ARH Medical Staff Executive Committee on August 20, 1997, resolved to seek legislative changes through the KMA to the extent there shall be no monetary liability on the part of physician members of the Kentucky Board of Medical Licensure (KBML) *except where actual malice is shown or willful misconduct is involved*; and

WHEREAS, the Kentucky legislature, pursuant to SD 177 in 1994, provided immunity from monetary liability for actual malice or willful misconduct on the part of physicians serving on the Kentucky Board of Medical Licensure; and

WHEREAS, all physician members of the KBML are required to abide by the Principles of Medical Ethics of the AMA; and

WHEREAS, there exists no satisfactory remedy for a Kentucky physician licensee who may be subjected to malice or willful misconduct by a physician member of the KBML; and



WHEREAS, Section II of the AMA Code of Ethics sets forth a physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception; and

WHEREAS, all members of the Kentucky Medical Association are required to abide by the AMA Code of Ethics; now, therefore, be it

RESOLVED, that KMA seek legislative changes in SB 177, returning to previous language holding physician members of the Kentucky Board of Medical Licensure monetarily responsible for any actual malice or willful misconduct toward a physician colleague whose conduct may be reviewed pursuant to SB 177.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A then heard testimony on Resolution 117, Revision of KRS 311, submitted by Francis C. Mappala, MD. Reference Committee A recommends rejecting Resolution 117.

RESOLUTION 97-124

Kentucky Forest Stewardship Act Estill County Medical Society

WHEREAS, lumber production is near record levels in Kentucky, indicating that timber from private forest land is being harvested at increasing rates due to availability and demand; and

WHEREAS, 17% of the state's native species are considered rare and at risk, and many of them reside in Kentucky woodlands; and

WHEREAS, one-third of Kentucky's native songbirds surveyed show long-term decline in populations, and many of these threatened populations depend on stable woodland environments; and

WHEREAS, improper logging operations threaten Kentucky water quality (with only 2% of the state's waterways currently considered high-quality); and

WHEREAS, the degradation and depletion of our natural resources not only affects our economic and ecological well-being, it threatens the very fabric of what makes Kentucky unique and special; and

WHEREAS, the Kentucky Natural Resources and Environmental Protection Cabinet has proposed a Kentucky Forest Stewardship Act containing key provisions such as logger certification, notification of logging, landowner education and incentives, and monitoring and reporting of forest health that are necessary to manage our forests in a sustainable manner, both now and for future generations; and

WHEREAS, Kentucky currently has little authority and resources to promote proper forest stewardship, making this legislation urgently needed to insure that our forests will continue to benefit the state; and

WHEREAS, these measures have been effective in other states, such as Virginia, and form a sound, cost-effective means for promoting forest stewardship; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports measures to protect Kentucky's biodiversity and water quality from improper logging practices in this era of increased extraction of Kentucky's woodland resources; and be it further

RESOLVED, that KMA considers the Kentucky Forest Stewardship Act proposed by the Natural Resources and Environmental Protection Cabinet to be necessary landmark legislation to manage Kentucky's forests in a sustainable manner, both now and for future generations.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A then considered Resolution 124, Kentucky Forest Stewardship Act, submitted by Estill County Medical Society. Reference Committee A recommends filing Resolution 124.

RESOLUTION 97-127

Full Licensure for Telemedicine Physicians Fayette County Medical Society

WHEREAS, technological advances have made it possible to carry out the practice of medicine by electronic means (telemedicine) from any distance within a state, across state lines, or even across international borders; and

WHEREAS, the expertise required to practice telemedicine should be as much as, if not more than, that required to practice "on-site" medicine, and

WHEREAS, it is the responsibility of the state to safeguard its citizens by certifying the expertise of individuals who practice medicine within this state; and

WHEREAS, the state would realistically have less ability to reprimand non-resident telemedicine physicians than physicians within the state; and

WHEREAS, the Ad Hoc Committee on Telemedicine of the Kentucky Board of Medical Licensure has recommended a plan of limited licensure for non-resident physicians practicing telemedicine in Kentucky; now, therefore, be it

RESOLVED, that the Kentucky Medical Association inform the Kentucky Board of Medical Licensure that we feel it is in the best interest of the health and safety of the citizens of this state that all non-resident physicians practicing telemedicine in Kentucky be required to have a full and unrestricted license to practice medicine in this state.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A then heard testimony on Resolution 127, Full Licensure for Telemedicine Physicians submitted by Fayette County Medical Society. Reference Committee A recommends adopting Resolution 127.

Mr Speaker, Reference Committee A recommends the adoption of this report as a whole.

Mr Speaker, I want to personally thank the other members of Reference Committee A who attempted to assist the House of Delegates in formulating policies on some very worthwhile issues. Members of the committee were: Gordon W. Air, MD, Crestview Hills; James R. Bean, MD, Lexington; Susan G. Bornstein, MD, Louisville; Joseph J. Dobner, MD, Frankfort; and Gay Fulkerson, MD, Leitchfield. I also wish to thank Ms. Carol Collett for her help and guidance in preparation of this report.

**Respectfully submitted,
REFERENCE COMMITTEE A
David J. Zoeller, MD, Elizabethtown, Chair
Gordon W. Air, MD, Crestview Hills
James R. Bean, MD, Lexington
Susan G. Bornstein, MD, Louisville
Joseph J. Dobner, MD, Frankfort
Gay Fulkerson, MD, Leitchfield (OMSS)**

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE B

Kathleen J. Bos, MD, Lexington, Chair

14. Report of the Scientific Program Committee
15. Report of the Scientific Exhibits Committee
16. Report of the Continuing Medical Education Committee
17. Report of the Council for Continuing Medical Education
18. Report of the Cancer Committee
19. Report of the Physician Workforce Committee
20. Report of the Organized Medical Staff Section
21. Report of the Rural Kentucky Medical Scholarship Fund
- Resolution 104 — Insulin as a Prescription Drug
(Pike County Medical Society)
- Resolution 105 — KMA Scientific Session Speakers
(Jefferson County Medical Society)
- Resolution 110 — Anesthesia
(Fayette County Medical Society)
- Resolution 119 — Medical Directors' and Managed Care Organizations' Tort Liability
(Jefferson County Medical Society)
- Resolution 121 — KMA International Medical Graduates (IMG) Section
(Floyd County Medical Society)
- Resolution 122 — Training Requirements for Medical Licensure
(Suvas G. Desai, MD)
- Resolution 128 — Unlicensed Physicians
(Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee B reviewed the following items and recommends they be filed, by consent of the House, without discussion:

14. Report of the Scientific Program Committee — filed
15. Report of the Scientific Exhibits Committee — filed
17. Report of the Council for Continuing Medical Education — filed
18. Report of the Cancer Committee — filed
19. Report of the Physician Workforce Committee — filed
20. Report of the Organized Medical Staff Section — filed
21. Report of the Rural Kentucky Medical Scholarship Fund — filed

Mr. Speaker, Reference Committee B recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Program Committee

"Patient Advocacy: The Physician's Essential Role" was chosen by the Scientific Program Committee as the overall theme for the 1997 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the meeting. The committee members and representatives of the planning committee from the 23 specialty societies have worked hard to bring some of the United States' top speakers to the meeting, and it is hoped that the membership will find their presentations practical and helpful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 23 specialty groups that will participate in the annual session. Specialty groups' scientific programs held in conjunction with the morning general sessions have proven to be very popular, and provide an excellent source for the continuing medical education of the membership. I personally appreciate the excellent cooperation the committee has had from all of the specialty societies in planning the overall meeting, and I thank them for their suggestions and assistance, and encourage them to continue to assist the committee in finding new and innovative ideas for topic selection and presentation.

The 1996 Annual Meeting was held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville, Kentucky, with an attendance of 2,072 total attendees.

Exhibitors were asked to fill out evaluation forms on Friday and Saturday during the 1996 meeting. This allowed a better assessment of exhibitors' viewpoints and new ideas which they may have for improving the meeting to be considered by the Scientific Program Committee. The exhibitors' comments were, overall, positive.

Results from physicians' evaluation forms from the general sessions and specialty group meetings were again positive and revealed that physicians attended the 1996 Annual Meeting program because of the availability of Category 1 CME credit, a friendly learning environment, speaker quality, and the overall program content. The Kentucky Medical Insurance Company again sponsored a Risk Management Workshop for Office Assistants, as well as a separate workshop for physicians.

The 1997 KMA Annual Meeting will be held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. Meetings of the KMA Board of Trustees, House of Delegates, reference committees, KEMPAC, and Alliance, as well as various food functions, will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall, as well as scientific and education exhibits, will be located in the Convention Center. We urge members and their staffs to visit the exhibits. These informal contacts offer numerous opportunities, education reviews, and discussion of new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

This year the Annual Meeting will shift back to a weekday format. The General Sessions and specialty group meetings will be held on Tuesday and Wednesday. The 1996 meeting was held on a weekend so that physicians could spend the weekend in Louisville and would not have to reschedule patients during the week. The weekend format did not produce the anticipated rise in attendance, so it was the decision of the Executive Committee and Scientific Program Committee to conduct the meeting over the regular weekday format.

The scientific sessions are again designated for AMA PRA Category 1 continuing medical education credit and are also approved for prescribed credit by the American Academy of Family Physicians.

As always, I am very grateful for the efforts of all those individuals who have assisted in the formation of another outstanding program, particularly the Program Committee, specialty group presidents, and program chairs. Suggestions for future programs are always welcomed by the Scientific Program Committee.

James L. Borders, MD
Chair

Report of the Scientific Exhibits Committee

Although the Scientific Exhibits Committee does not meet formally, the work that is put into the scientific exhibits area continues to be a strong component of the overall success of the Annual Scientific Meeting. The activities of the committee are carried out by mail and telephone. We notify members through the *Journal of the Kentucky Medical Association* and the *KMA Communicator* of the availability of space and provide applications to interested individuals. In 1996, thirteen outstanding scientific exhibits were approved by the Scientific Exhibits Committee. We also provide exhibit space for entities such as the Impaired Physicians Program. We wish to express our appreciation to the following exhibitors at the 1996 Annual Meeting:

- **Diabetes 2000**
Kentucky Academy of Eye Physicians and Surgeons
- **Screening for Spinal Deformity**
John J. Vaughan, MD; H. Brooks Morgan, MD; B. Chris Stephens, MD
- **Natural History of Scoliosis and Kyphosis in Adult Cerebral Palsy**
Mohammad Majd, MD; David Muldowney, MD; Jorge Isaza, MD; Richard T. Holt, MD
- **The Effect of Premarin on the Excessive Postoperative Drainage After Posterior Lumbar and Lumbosacral Vertebral Fusion**
Jorge E. Isaza, MD; Yong K. Liu, MD; Richard T. Holt, MD
- **Growing Rod: Our Experience with a New Technique**
Kevin Rahn, MD; Jorge E. Isaza, MD; Richard T. Holt, MD
- **Spine Surgery on the Internet**
Mark K. Crawford, MD; Richard T. Holt, MD; Jorge E. Isaza, MD
- **Vertebral Rotational Plasty: A Technique for Anterior Column Reconstruction**
Jorge E. Isaza, MD; Richard T. Holt, MD
- **Terminal Cancer Symptom Management by House Staff**
Paul Sloan, MD
- **Chronic Pain and Soft Tissue Injuries After Motor Vehicle Accident**
Manoochehr Mazloomdoost, MD

We would also like to congratulate "Surgery for Cervical Disk Disease: A Retrospective Database of 2,000 Patients," which is the recipient of the 1996 Award of Excellence.

I want to take this opportunity to thank the members of the committee for their dedication in serving on the Scientific Exhibits Committee. The scientific exhibits area continues to be a significant and substantial portion for the exchange of necessary and practical scientific information at the Annual Scientific Meeting, and we feel that it is worth all physicians' time to stop at the scientific exhibits area during the Annual Meeting and visit with the scientific exhibitors.

Richard A. Kielar, MD
Chair

Report of the Council on Continuing Medical Education

The Council on Continuing Medical Education convened for two regular meetings this year, both in conjunction with the CME Committee.

The council provides CME credit for association educational meetings, and therefore works closely with the Scientific Program Committee in planning the Annual Scientific Program to ensure that quality education is offered for Category 1 CME credit. The council reviewed the theme "Patient Advocacy: The Physician's Essential Role" and the draft of the program for the 1997 KMA Annual Meeting, including speakers, topics, and learning objectives. The council discussed the summary of evaluation forms from the 1996 meeting, and monitored changes which the Scientific Program Committee made based on attendees' comments. One major change noted was moving the format of the Annual Meeting back to a weekday. A formal



survey undertaken three years ago showed that physicians were interested in having the Annual Meeting over a weekend. The 1996 meeting was to experiment with a weekend format so that physicians could spend a weekend at the meeting and not have to close their offices during the week. The experiment did not produce anticipated attendance results, so the Program Committee recommended holding the meeting over a weekday format in 1997.

The council continues to monitor the activity of the Accreditation Council on Continuing Medical Education (ACCME) from which it receives its accreditation. The ACCME is in the process of changing the accreditation system to better facilitate physician education in the changing health care delivery system. With the dedicated group of physicians on the council, it is expected that KMA's CME program will adapt readily to any new national accreditation system that the ACCME might implement.

One new educational opportunity that the council has approved for 3 hours of Category 1 AMA PRA CME credit is "Domestic Violence: The Role of the Physician in Breaking the Cycle." Through a survey to a random sample of 500 physicians in Kentucky, it was determined that physicians were interested in receiving quality education on issues related to domestic violence issues. Of those responding to the survey, 76% indicated they would like education on domestic violence. Since 3 hours of domestic violence training is now required by the state of Kentucky for licensed primary care physicians, the KMA will be holding a three-hour seminar for primary care physicians at the 1997 Annual Meeting.

The council also jointly sponsored several programs this year. The council approved a need from the Kentucky Academy of Eye Physicians and Surgeons to jointly sponsor its spring/summer meeting in June. The meeting attracted over 60 physicians and the speakers were excellent and met the learning objectives for the program.

The council jointly sponsored the program of the Kentucky Society of Anesthesiologists in May for 10 hours of Category 1 CME credit. While attendance at the program dipped from past years, the evaluations showed that the speakers and subject matter were rated as one of the best meetings that the KSA has held.

Finally, the council jointly sponsored the summer meeting of the Kentucky Otolaryngological Society in June for 11 hours of Category 1 CME credit. Over 50 attendees enjoyed the content of the program and rated a majority of the speakers as excellent.

I would like to thank the members of the Council on CME who served as site surveyors for the accreditation program under the auspices of the CME Committee. While it is not the responsibility of the council members to do so, many of them took time out of their busy schedules to lend their expertise in surveying hospitals and other organizations in order to improve their physician education programs.

During the coming year, the council will continue to monitor the work of the ACCME and look to make adjustments accordingly to our own system of providing CME. The council would like to thank the Board of Trustees for permission to serve, and looks forward to the activity in 1997-98.

James L. Borders, MD
Chair

Report of the Cancer Committee

The purpose of the Cancer Committee is to promote the continuing study of patient screening, prevention, education, and treatment of the disease. The committee serves as a liaison with medical schools, cancer treatment centers, and the Kentucky Chapter of the American Cancer Society. This year the Cancer Committee continued its efforts to monitor, participate in, and encourage a variety of services to address this disease.

The KMA House of Delegates passed Resolution 119 in 1996 which recommends that written summary information allowing alternatives in the treatment of breast cancer, as mandated by statute, contain information about psychosocial counseling resources and reconstructive surgery options.

The committee noted that the booklet *CHOICES* is required to be given to all cancer surgery patients. To help promote wider dissemination of this information, the committee has investigated advertisement of the booklet in the *KMA Journal*, making it available at the Annual Meeting, and has requested that cancer centers consider including counseling resources and reconstructive surgery options in the booklet. The committee also noted a

recent study in *The New England Journal of Medicine* showed legislation appeared to have only a slight and transient effect on breast cancer treatment methods.

Through the Brown Cancer Center and participation by committee members, a mastectomy versus breast conservation study being conducted in the Kentuckiana area is to be completed in two phases. An initial pilot study is to be done in Louisville through Jewish and Norton hospitals and then expanded to all hospitals in the state, hopefully. A universe of 200 patients is being sought to constitute a representative sample.

A questionnaire has been created to better understand the important issues affecting women recently diagnosed with breast cancer and who have undergone breast surgery. The ultimate purpose of the study is to improve breast cancer treatment in the state. A similar study has been done at the Western Baptist Hospital in Paducah. In a review of this effort, the committee proposed that the study include mailing questionnaires to patients that do not have access to a phone, characterizing patients by income, and trying to determine insurance resources that they might have. As this study progresses, hopefully these information elements can be included. The committee continues to support the efforts of the cancer registry which is a legislatively established, population-based central registry for the state. Supposedly all cancer cases are subject to mandatory reporting to the registry from acute care hospitals, associated outpatient facilities, and unassociated outpatient facilities. Other health care facilities are supposed to report as well.

Data from the registry is used in periodic information and training programs throughout the state to assist hospitals in uniformly reporting cases. Overall, this data is used in concert with local hospitals, health departments, physicians, and cancer councils to target cancer control efforts. Hopefully, summary data can be periodically made available to the membership.

The committee is likewise indirectly involved in the Louisville/Jefferson County partnership in cancer control which is a coalition of 20 organizations. The partnership was founded in 1995 to address the cancer problem among the high-risk African-American population. The partnership has initiated a demonstration project to increase access to low-cost breast and cervical cancer screening services, hopes to develop a community-based publication and treatment program, is attempting to develop intervention strategies for physician offices to increase referrals, and includes a post-screening follow-up evaluation component. The specific target population of this effort is African-American women over the age of 40 who are socioeconomically disadvantaged and live in medically underserved areas of Jefferson County.

Through the partnership efforts, a portable mammography unit and a transport van to provide mammography services in conjunction with clinical breast exams and pap tests have been funded, and these services have been performed by the clinical staff at the Family Health Center — Portland, the Park DuValle Community Health Center, and the Newburg Primary Care Center in Louisville. Private practice physicians may also refer income-eligible women to this service.

The partnership is seeking additional funding which it will use to expand the community outreach and education efforts to other communities and to continue working with private practice physicians.

The committee is also involved with the Kentucky Cancer Consortium with the chair serving as a member. The KMA has provided data on physician and facility access to the consortium on a periodic basis during the year.

The committee appreciates the confidence the Board of Trustees has indicated for its efforts and hopes to increase these monitoring, prevention, and education activities individually, and as the committee, in the coming year. As committee chair, I would like to thank each of the individual members for their devotion to the committee's work as well as their dedication to cancer treatment efforts.

Harry W. Carloss, MD
Chair

Report of the Physician Workforce Committee

The Physician Workforce Committee did not meet formally this year, but conducted most of its business through phone contact and correspondence.

In January, a letter was directed to Governor Paul E. Patton regarding Resolution 102 — New Kentucky Medical School. It was noted in the letter that the committee has monitored the physician workforce needs of Kentucky throughout the past ten years and recognizes that the education needs of our

country are changing. Managed care, technological advances, and an increase in individual self-responsibility for healthy lifestyles, are effecting changes in the demand for medical resources. Among the factors which should be considered in the establishment of an additional medical school in the Commonwealth is the effect on existing medical schools. The committee encouraged Governor Patton to thoughtfully consider these factors in any serious plans of establishing a third medical school in Kentucky.

On the national level, the committee observed several important workforce issues that have come about and have attracted the attention of the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the Institute of Medicine (IOM), the Association of Academic Health Centers (AAHC), the National Medical Association (NMA), the American Osteopathic Association (AOA), and the American Association of College Osteopathic Medicine (AACOM) to name a few.

The US health care system is facing a serious dilemma due to the federal government funding graduate medical education (GME) positions in excess of the number actually needed. Currently, the United States has an abundance of physicians and either now has, or soon will have, a surplus, at least in certain regions and specialties. The size of the surplus depends on a number of factors, such as the extent and nature of changes in health care delivery systems; the financing structure for health care; technological breakthroughs; mechanisms used to finance graduate medical education (GME); shifts in rate of immigration and entry into practice of international medical graduates (IMGs); use of nonphysician health personnel; changes in physician demographics, practice styles, and arrangements; and patients' need and demand for health care. The impact of the surplus may vary by specialty and geographic region, but steps are needed by the federal Government to ensure that the nation produces the best physicians it can in appropriate but not excessive numbers.

A consensus statement from the AACOM, AMA, AOA, AAHC, AAMC, and the NMA includes the following recommendations:

1. The number of entry level positions in the country's GME system should be aligned more closely with the number of graduates of accredited US medical schools. This realignment should be achieved primarily by limiting federal funding of GME positions. Since in the United States all physicians must complete a period of GME before being licensed to practice medicine, the number of funded positions should be sufficient to allow all MD and DO graduates of accredited US medical schools an opportunity to enroll in an accredited GME program.
2. The United States should continue to provide GME opportunities for foreign-born physicians who have graduated from non-US medical schools. These physicians should participate in GME under the J-1 Exchange Visitor Program. Their training should not be financed from Medicare funds currently dedicated for the support of GME, or from any national all-payer GME fund that might be established in the future. It is important that these physicians return to their country of origin after completing GME in this country. To ensure this, the government should eliminate all waiver programs that allow these physicians to remain in the United States if they agree to accept a practice position in a state or federally designated medically underserved area. As noted below, the government should attempt to meet the needs of these communities by expanding existing programs (for example, the National Health Services Corps) or establishing new programs designated to recruit US graduates to these practice positions.
3. It is likely that many underserved communities will continue to have an inadequate number of physicians, particularly generalist physicians, to meet the needs of the population. Given the existence of physician oversupply, it is clear that this problem will not be solved by increasing the supply of physicians. At present, there is no federal program that provides funds explicitly for the purpose of establishing new medical schools or expanding the enrollment of existing schools, and no federal program should be established for this purpose. The communities that are traditionally underserved are characterized by location — rural or inner city — or by the race and ethnicity of the population. To increase the likelihood that US medical school graduates will establish practices in these communities, federal funds should be provided to encourage and support medical school efforts to expand the opportunities students have to gain experience in rural and inner city communities so that they will have an appreciation of the needs and challenges of practice in these

communities. Historically, minority physicians have been more likely than nonminority physicians to establish practices in communities with minority populations. Given this, medical schools should be supported and encouraged in their efforts to increase the diversity of their student bodies so that they will be able to graduate an increasing number of their students who might establish practices in traditionally underserved communities, and federal incentives should be provided to encourage students to pursue careers as generalist physicians and to establish practices in these communities.

4. Changes occurring in the financing of medical care are eroding the individual revenue streams that have supported GME for the past three decades. A national all-payer fund should be established to provide a stable source of funding for the direct costs of GME (resident stipends and benefits, faculty supervision and program administration, and allowable institutional costs). Payments should be made from this fund to entities, such as consortia, that have been designated to receive funds on behalf of the entities incurring the costs. In the meantime, the formula used currently by the Medicare program to determine capitated payments to managed care organizations should be revised to ensure that the funds intended for the support of GME are used for that purpose.
5. Teaching hospitals that lose resident physicians as a direct result of the reduction in the number of entry level positions in the GME system should receive transitional funds to assist them in establishing alternative methods of delivering services that formerly involved resident physicians. This is particularly critical for those institutions that have traditionally used resident physicians to provide services to the poor.
6. There are a number of reasons why teaching hospitals incur higher costs than nonteaching hospitals in providing patient care — the complex nature of the patients cared for in these institutions, the participation of health professions students in the delivery of care, the development and deployment of new diagnostic and therapeutic technologies, and the conduct of concurrent clinical research activities. Historically, these costs have been funded through special types of reimbursement (most notably, the Medicare Indirect Medical Education Adjustment) and higher payment levels for patient care services. Given changes occurring in the financing of health care services, a stable source of funding for these activities must be established.
7. A national physician workforce advisory body should be established to monitor and periodically assess the adequacy of the size and specialty composition of the physician workforce in the context of the changing needs of the evolving health care delivery system and evolving patterns of professional practice by nonphysician health professionals. This body should be legislatively mandated, but staffed independently of existing government agencies. In order to meet its responsibilities, the body should have a budget that is adequate to support an appropriate staff and to allow the staff to conduct necessary analytic work. The government should continue to provide funds to support research on workforce issues.

The committee will continue to follow the issues at the state and national level and how they will affect the workforce of physicians in Kentucky. I would like to thank the Board for being permitted to serve and look forward to expanded activity in 1997-98.

Robert R. Goodin, MD
Chair

Report of the Organized Medical Staff Section

The Organized Medical Staff Section (OMSS) was formed to help ensure that practicing physicians have a leadership role in the governance of hospitals, other health facilities, and emerging delivery systems through a self-governing medical staff. The role of this staff is to advocate for high-quality patient care, responsible professional patient care standards, ethical principles of physician practice, and the value of medical services delivered.

This year the OMSS furthered its implicit mission to provide a forum for education and interchange of ideas on OMSS issues by holding a seminar in October in Louisville. At this seminar, the group was fortunate to have as distinguished presenters Lee H. McCormick, MD, immediate past chair of the AMA-OMSS; William Monnig, MD, a founding member of the KMA-OMSS and current Secretary of the AMA-OMSS Governing Council; as well as individuals active in-state from the steering committee, the hospital association, managed



care plans, and lay staff administrators. Each provided the forum with insight in their areas of expertise and beneficial information on "hands-on" activities experienced in their own practice and work settings. The OMSS is particularly grateful to Jewish Hospital of Louisville, which hosted this function in the Rudd Heart and Lung Center.

At the national level, the KMA-OMSS is well represented to the AMA-OMSS. In addition to Dr Monnig, who has already been acknowledged, your OMSS chair has had the privilege of serving this year on an advisory committee to develop strategic plans for AMA-OMSS functions nationally. At AMA-OMSS meetings, Kentucky has been further represented by Harold L. Bushey, MD, Barbourville; James R. Bean, MD, Lexington; Uday V. Dave, MD, Madisonville; Satish J. Shah, MD, Madisonville; Alfred L. Thompson, MD, Louisville; Preston P. Nunnelley, MD, Lexington; and Donald J. Swikert, MD, Florence.

From a national perspective, a number of priorities have been developed for address by the AMA as well as state sections. These include the impact of decreasing reimbursement for medical services on patient care access and quality; the erosion of medical decision-making; standards for data collection; the unilateral imposition of medical staff development plans and economic credentialing controlled by hospitals; managed care eligibility; the responsibility of managed care entities, their employees, agents, and representatives relating to economic management of medical care; continuing medical education activities for procedural skills; and for-profit conversions of health care organizations.

For the coming year, it is hoped that sufficient momentum can be created among concerned Kentucky practitioners to develop plans for implementation in some of these action areas. While managed care appears to be the obvious focus of the medical community, whether voluntarily or involuntarily, the OMSS remains committed to physician control of medical practice and responsibility for the quality of patient care. We will continue to work toward these ends.

John D. O'Brien, MD
Chair

Report of the Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc. (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians in Kentucky. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipients practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay their loans at a discounted interest rate which is determined yearly. Interest accrues from the date of the loan until the loan is paid in full.

For the academic year 1997-98, the RKMSF offered scholarship loans to 12 new applicants in the amount of \$12,000 each, and 14 loans to prior student recipients, said loans totaling \$312,000. Last year a total of \$216,000 was expended in scholarship loans. In 1995-96 \$170,000 was expended.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted approximately 648 loans. In 1997-98, the fund had no graduating seniors entering primary care residency programs; 18 recipients are currently enrolled in residency programs; and 8 recipients are entering the full-time practice of medicine in 1997. There were 4 recipients who received forgiveness of loans in 1996-97 and 2 recipients completed their financial and/or practice obligations in 1996-97.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to practicing physicians to assist in paying prior educational loans. For each year a physician in the EPGP practices in a critical county, they will be granted \$10,000 to be used toward an educational debt, with a maximum of \$40,000 granted per physician.

One physician is currently participating in the EPGP. Since its inception in 1989, there have been a total of 10 participants in the EPGP. Currently, there are 4 vacancies in the Establish Practice Grant Program.

The RKMSF has two main sources of income: interest accrued on the

scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just over one year, with an average yield of 5.64%.

The Kentucky Medical Association continues to provide financial and other support to the RKMSF which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own officers and Board of Directors. This report is furnished as an informational item.

Donald R. Stephens, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Continuing Medical Education Committee

The CME Committee continues to oversee the accreditation of organizations in providing continuing medical education for physicians. The committee met on four occasions this year.

One of the main topics of discussion at every meeting this year were initiatives of the Accreditation Council on Continuing Medical Education (ACCME) to restructure the accreditation process. The ACCME is the national body which, on one hand, accredits state medical societies and other organizations to provide CME, but also empowers and recognizes state medical societies to accredit hospitals and other health care organizations within their state to provide CME activities. The ACCME is looking to streamline the accreditation process to allow sponsors to be innovative and more efficient in providing continuing medical education to physicians in the ever-changing health care delivery system. The committee looks to the ACCME's restructuring with much interest since we must meet ACCME's guidelines in managing our own CME accreditation system.

The current accreditation process consists of the committee assisting organizations in developing a working education program and then monitoring organizations' programs through formal surveys. Health care organizations in Kentucky receive accreditation from the committee so they can, in turn, conduct their own individual CME activities.

Initial surveys this year were conducted for four institutions which had applied for accreditation. All four applicants were approved and granted up to a two-year provisional accreditation period, with an interim report to be filed at the midpoint of the accreditation cycle. Surveys were also conducted for 17 institutions which had applied for reaccreditation. Five institutions applying for reaccreditation were approved and granted an accreditation period of four years based on their ability to meet the criteria of the KMA Essentials, which all organizations must demonstrate to become accredited. Seven organizations were given a three-year accreditation period, and four organizations were given a two-year accreditation cycle.

The initial accreditation process assumes six steps. First, an organization submits a preliminary questionnaire to the KMA Headquarters Office. When the preliminary questionnaire is deemed appropriate, the organization submits an application to the KMA; the survey team then reviews the application and determines if the organization is ready for a survey; a survey is conducted; the survey team formulates a survey report with suggestions for improvement to the organization, as well as a recommendation regarding the accreditation period to the CME Committee; and the survey report is subsequently voted on by the committee as a whole. After the committee approves an accreditation status, it notifies the organization of the accreditation period. The reapplication process is essentially the same format without the preliminary questionnaire. The committee also requires an interim report from the organization at the midpoint of the accreditation period so the committee can continue to monitor and assist the organization between surveys.

The committee continues to provide input at the national level regarding changes in CME. Robert R. Goodin, MD, updates the committee regularly on the business of the AMA Council on Medical Education, of which he is a member. Dr Goodin reported that the accreditation restructuring is looking to be streamlined by the ACCME in order to improve the efficiency of the accreditation process. The main impetus for change by the ACCME is to help physicians stay educated in accordance with the changing nature of the health care delivery system.

James L. Borders, MD, attended the ACCME/State Medical Society

Conference and reported that the ACCME is also trying to redesign Essential #7 — Joint Sponsorship. Currently, sponsors must be integrally involved in planning CME activities for joint sponsorship. The ACCME is looking into ways of facilitating joint sponsorship so that more quality CME can be provided. The committee will continue to stay abreast of the ACCME transition in order to transmit the best way to educate physicians thorough seminars, conferences, didactic lectures, etc. The committee will make appropriate changes at the state level when the ACCME has a new system to present.

The committee continued its annual solicitation for nominees for the Educational Achievement Award. Since the committee revised the criteria several years ago, the field of candidates continues to be extremely strong. Eight nominations were received and considered; one recipient was selected by the committee. The recipient was Ward O. Griffen, MD, a retired Lexington surgeon.

The committee reviewed its policy on intrastate accredited organizations sponsoring national/international meetings, and adopted the following policy:

Institutions which are accredited as CME sponsors by the Kentucky Medical Association are assumed to be serving physicians in their own geographic area (defined as Kentucky and its immediately bordering states of Ohio, Indiana, Tennessee, Missouri, Illinois, West Virginia, and Virginia). It is inappropriate for KMA-accredited institutions to sponsor or jointly sponsor activities which are directly advertised to physicians outside this geographical area on a regular and recurring basis.

Institutions wishing to implement nationally advertised activities must either apply for national CME accreditation from the Accreditation Council for Continuing Medical Education (ACCME) or conduct these activities under joint sponsorship with an institution that is ACCME accredited.

By special letter of request to the Committee on Continuing Medical Education, KMA-accredited institutions may receive approval to implement one nationally advertised activity per year.

Requests must be submitted to the committee in writing 90 days before the program is to be held and contain sufficient information to justify approval.

Approval of such requests will be based on the following criteria:

- Nature of the activity's educational objectives and subject content.
- Geographical scope of the justified need and audience appeal.
- The abundance and geographical distribution of physicians within the primary target audience.

Institutions planning to implement a nationally advertised activity are encouraged to contact KMA early in the planning process to assure committee approval prior to program promotion deadlines.

Finally, the committee will be resurveyed by the ACCME's Committee for Review and Recognition Survey Team in August. The committee expects a positive review by the survey team and will communicate the results of the survey as they are known.

The committee is planning its annual "CME Accreditation Process Seminar" for November. This annual event draws approximately 80 attendees, ranging from physician CME chairpersons to CME coordinators, and allows a chance for the committee members and physician educators in Kentucky to interact.

The committee anticipates another busy year in 1997-98.

Thomas K. Slabaugh, MD
Chair

Recommendations, Reference Committee B:

Reference Committee B reviewed the Report of the Continuing Medical Education Committee. The committee would like to congratulate the 1996 recipient of the Educational Achievement Award, Dr. Ward O. Griffen, a retired Lexington surgeon. Reference Committee B recommends that Report 16 be filed.

Resolution 97-104

Insulin as a Prescription Drug Pike County Medical Society

WHEREAS, Food and Drug Administration rules and patent regulations have allowed the retail sale of a number of pharmaceutical products directly

to patients, which is appropriate for those medications with little potential for misuse or abuse; and

WHEREAS, some medications require close medical supervision of using patients to assure appropriate frequency and strength of ingestions, physical regulation and revision, and dosage determinations based on individual patient condition needs; and

WHEREAS, insulin is not a benign medication which can have significant negative effects if its use is not properly monitored, and it is generally available for retail purchase without prescription; and

WHEREAS, inappropriate use of insulin by diabetics can result in increased long-term morbidity and mortality; now, therefore, be it

RESOLVED, that KMA work with the Kentucky Board of Medical Licensure and other appropriate agencies to require that all forms of insulin be designated as controlled medication necessitating a physician prescription; and be it further

RESOLVED, that the Kentucky Medical Association holds that properly controlled prescription, dispensing, and use of medication can prevent bad or unintended results, improve patient compliance and health, and result in positive medical, as well as financial, outcomes for patients.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 104, Insulin as a Prescription Drug, submitted by Pike County Medical Society. The committee recommends that the first and second Resolves be amended to read:

RESOLVED, that the KMA work with the Kentucky Board of Medical Licensure and other appropriate agencies to require that all forms of insulin be designated as controlled medication necessitating a physician prescription; and be it further

RESOLVED, that the Kentucky Medical Association holds that properly controlled prescription, dispensing, and the use of medication can prevent bad or unintended results, improves patient compliance and health, and result in positive medical, as well as financial, outcomes for patients.

Mr. Speaker, Reference Committee B recommends Resolution 104, as amended, be referred to the Board of Trustees.

Resolution 97-105

KMA Scientific Session Speakers Jefferson County Medical Society

WHEREAS, the KMA Executive Committee has set forth a policy on reimbursement of guest speakers invited by the Scientific Program Committee; and

WHEREAS, this policy states that the KMA will pay an honorarium and expenses for one speaker per specialty group who appears on the General Sessions Program of the Annual Meeting, providing this guest speaker resides outside the state of Kentucky and is a physician; and

WHEREAS, these requirements have the potential to prevent the foremost expert on a topic from participating if that expert is a nonphysician within the state of Kentucky; and

WHEREAS, the officers and staff of KMA were most helpful, but existing policy required that they make an exception in order to provide the most qualified speaker in at least one recent meeting; now, therefore, be it

RESOLVED, that the Kentucky Medical Association, inclusive of the 1997 Annual Meeting, revise the Executive Committee's policy on eligibility and reimbursement of Scientific Program guest speakers in order to allow the best qualified experts to participate, regardless of their professional backgrounds or states of residency.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 105, KMA Scientific Speakers, submitted by the Jefferson County Medical Society. Reference Committee B recommends that it be amended by deleting the Resolved and substituting a new Resolved:

RESOLVED, that the Kentucky Medical Association review its policy on Scientific Program Speaker selection to allow the best qualified experts to participate.



Resolution 97-110

Anesthesia

Fayette County Medical Society

WHEREAS, anesthesia for diagnostic and therapeutic procedures carries inherent and significant risks to patients' lives; and

WHEREAS, studies have shown that patients' satisfaction is highly correlated with the consultation of an anesthesiologist preoperatively; and

WHEREAS, studies have shown that patients' safety, satisfaction, and the cost of care are all favorably impacted by the services of an anesthesiologist throughout the preoperative, intraoperative, and postoperative phases of the surgical experience; and

WHEREAS, the Anesthesia Patient Safety Foundation of the American Society of Anesthesiologists has made, and continues to make, highly significant advances, and perhaps the most significant advances of any such organization in favorably affecting patients' safety during anesthesia; and

WHEREAS, the presence on the hospital staff of an anesthesiologist has been shown to correlate better with lowering intraoperative morbidity and mortality than any other single factor; and

WHEREAS, the Foundation for Anesthesia Education and Research has supported and continues to support major initiatives in education and research; now, therefore, be it

RESOLVED, that anesthesia is the practice of medicine in the state of Kentucky, and it is highly desirable that whenever and wherever possible general anesthesia should be administered, or directed, by a physician who has satisfactorily completed an accredited residency in anesthesiology.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 110, Anesthesia, submitted by the Fayette County Medical Society.

The reference committee heard extensive support both from the floor and within the committee and recommends that Resolution 110 be amended through the addition of the phrase, "the administration of" as well as the phrase "epidural, spinal and." The new Resolved will read as:

RESOLVED, that the administration of anesthesia is the practice of medicine in the state of Kentucky, and it is highly desirable that whenever and wherever possible epidural, spinal and general anesthesia should be administered by, or directed by a physician who has satisfactorily completed an accredited residency in anesthesiology.

Reference Committee B recommends that Resolution 110 be adopted as amended.

An amendment was offered from the floor of the House to insert "appropriately trained" before "physician" in line 11 and delete the remaining text, to read:

RESOLVED, that the administration of anesthesia is the practice of medicine in the state of Kentucky, and it is highly desirable that whenever and wherever possible epidural, spinal and general anesthesia should be administered by, or directed by an appropriately trained physician who has satisfactorily completed an accredited residency in anesthesiology.

Resolution 97-110 was adopted as amended from the floor.

Resolution 97-119

Health Carriers' and Managed Care Organizations' Tort Liability

Jefferson County Medical Society

WHEREAS, medical directors, nurses, and other employees of insurance companies, health maintenance organizations, and managed care networks are deciding whether a treatment or procedure recommended by the patient's attending physician is medically necessary; now, therefore, be it

RESOLVED, that the medical directors of insurance companies, health maintenance organizations, and managed care networks serving patients in Kentucky be required to be licensed by the Commonwealth of Kentucky and to fall under jurisdiction of the Kentucky Board of Medical Licensure; and be it further

RESOLVED, that health carriers and managed care organizations and their employees who make decisions which result in patient injury should be held legally responsible for their decisions; and be it further

RESOLVED, that the Kentucky Medical Association further these views

by promoting the introduction and passage of legislation to these ends at the next session of the Kentucky General Assembly.

Resolution 97-128

Unlicensed Practice

Fayette County Medical Society

WHEREAS, there is evidence concerning the adverse impact and potential harm to patients resulting from the influence of unlicensed individuals on the medical decision-making process of Kentucky physicians; and

WHEREAS, an effort should be made to protect patients by preserving the independent medical judgment of physicians of Kentucky; and

WHEREAS, reviewers, insurers, medical directors, and managed care gatekeepers, as well as those individuals making medical decisions via telemedicine, are attempting to become more influential in the decision-making process concerning care of patients; and

WHEREAS, the determination of medical necessity or appropriateness of proposed care that affects the diagnosis or treatment of a patient is the practice of medicine; and

WHEREAS, to engage in the determination of medical necessity or appropriateness of an evaluation or care so as to affect the diagnosis or treatment of a patient in Kentucky requires a Kentucky medical license; and

WHEREAS, a person physically located in another jurisdiction, who through any medium performs an act that is part of a patient's service initiated in the state of Kentucky and which would affect the diagnosis or treatment of a patient, is also engaged in the practice of medicine so as to require a Kentucky medical license; and

WHEREAS, the exercise of decision-making authority over the need for appropriateness of medical evaluation or care so as to affect diagnosis or treatment is the practice of medicine, and consequently such activity requires a Kentucky medical license; now, therefore, be it

RESOLVED, that the Kentucky Board of Medical Licensure should issue a position statement that those individuals or entities that make a determination of medical necessity or appropriateness of any medical evaluation or care so as to affect the diagnosis or treatment of a patient in Kentucky shall hold a current Kentucky medical license.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 119, Health Carriers' and Managed Care Organizations' Tort Liability, submitted by Jefferson County Medical Society, and Resolution 128, Unlicensed Practice, submitted by Fayette County Medical Society.

Reference Committee B recommends that Resolution 119 be amended by deleting the final Resolved.

Reference Committee B recommends that Resolution 119, as amended, be adopted in lieu of Resolution 128.

A new third Resolved was offered on the floor of the House, to read:

RESOLVED, that the Kentucky Medical Association be encouraged to further these efforts through its interactions with the Kentucky Board of Medical Licensure, available legislative venues, and the American Medical Association.

Resolution 97-119, as amended, was adopted in lieu of Resolution 128.

Resolution 97-121

KMA International Medical Graduates (IMG) Section

Floyd County Medical Society

WHEREAS, the American Medical Association has approved an International Medical Graduates Section; and

WHEREAS, the IMG physicians of Kentucky represent 18.4% of all licensed physicians in the state of Kentucky, or 1,458 IMGs of 7,553 licensed physicians; and

WHEREAS, the IMG physicians contribute significantly to improving quality care in Kentucky, especially in the rural areas of Kentucky; now, therefore, be it

RESOLVED, that the KMA create a Kentucky IMG section; and be it further

RESOLVED, that the IMG section have status equal to that of other KMA societies.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 121, KMA International Medical Graduates (IMG) Section, submitted by Floyd County Medical Society.

Reference Committee B heard positive support regarding this resolution from the KMA President, Doctor Mitchell. The committee members felt further delineation of the section should be addressed by interested parties and the Board of Trustees.

Reference Committee B recommends that Resolution 121 be referred to the Board of Trustees.

Resolution 97-122

Training Requirements for Medical Licensure

Suvas G. Desai, MD

WHEREAS, Kentucky Revised Statute 311.571 (2) (f) requires that an applicant for medical licensure must complete three years of prescribed postgraduate training to be eligible to apply for a regular license; and

WHEREAS, this requirement pertains to applicants who are graduates of medical or osteopathic schools outside the United States or Canada; and

WHEREAS, the Board of Medical Licensure has recently agreed that this postgraduate training requirement should be reduced from three to two years; and

WHEREAS, such a change would require revision of KRS 311, et al; now, therefore, be it

RESOLVED, that KMA supports a change in the postgraduate training requirement for medical licensure from three to two years for applicants from schools located outside the United States or Canada; and be it further

RESOLVED, that KMA work with the Board of Medical Licensure to seek appropriate revision of KRS 311 to effect this change.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 122, Training Requirements for Medical Licensure, submitted by Suvas G. Desai, MD.

Reference Committee B heard favorable support of this resolution from representatives of the Board. Reference Committee B also heard acknowledgment that the Board of Medical Licensure is currently reviewing these requirements.

Reference Committee B recommends that Resolution 122 be referred to the Board of Trustees.

Mr. Speaker, I recommend the adoption of the report of Reference Committee B as a whole, as amended.

Mr. Speaker, I would like to personally thank the other members of Reference Committee B who have assisted in the formulation of this report. The other members of the committee were: Gilroy L. Daley, MD, Hazard; James P. Farrell, MD, Crestview Hills; Mohan K. Rao, MD, Madisonville; Bryce E. Schuster, Louisville. I also want to personally thank Ms. Michelle Phelps for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE B
Kathleen J. Bros, MD, Lexington, Chair
Gilroy L. Daley, MD, Hazard
James P. Farrell, MD, Crestview Hills
Mohan K. Rao, MD, Madisonville
Bryce E. Schuster, Louisville (MSS)

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE C

Lela C. Maynard, MD, Pikeville, Chair

23. Report of the Committee on National Legislative Activities
24. Report of the Committee on State Legislative Activities
25. Report of the Committee on Professional Liability Insurance
26. Report of the Committee on Care of the Elderly
27. Report of the Public Education Committee

Resolution 103 — Mandatory HIV Education for Physicians
(Warren County Medical Society)

Resolution 108 — Medicare Audits
(Jefferson County Medical Society)

Resolution 120 — Mandatory Domestic Violence Educational Requirements for Primary Care Physicians
(Warren County Medical Society)

Resolution 126 — Mandatory Domestic Violence Education for Primary Care Physicians
(Henderson County Medical Society)

Resolution 131 — Physician Participation in Capital Punishment
(Board of Trustees)

Resolution 132 — Fraud and Abuse
(Board of Trustees)

Resolution 133 — Gag Clauses
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee C reviewed the following items and recommends they be filed, by consent of the House, without discussion:

23. Report of the Committee on National Legislative Activities — filed
25. Report of the Committee on Professional Liability Insurance — filed
26. Report of the Committee on Care for the Elderly — filed
27. Report of the Public Education Committee — filed

Mr. Speaker, Reference Committee C would like to express its appreciation to the authors of these reports which have been filed and for their efforts spent in preparing these reports for the House of Delegates. Reference Committee C recommends the adoption of the Consent Calendar as a whole.

Report of the Committee on National Legislation

As this report is being written, Congress has not finalized the federal budget thus making it difficult to provide a full and factual report on national legislation and its effect upon the practice of medicine and patient care. Senate and House leadership and the Clinton Administration continue to seek agreement on several important concerns for physicians. While this report will not detail individual issues, every Kentucky physician should participate in the lobbying effort by following the budgetary negotiations through local media or AMA/KMA publications and follow up by contacting their elected representatives. This has been a very busy year on the legislative front as AMA and KMA dealt with the following major concerns:

- \$5.3 billion reduction in Medicare physician payments over five years
- The validity of HCFA's use of new resource-based practice expense
- Inappropriate fraud and abuse legislation which may have a chilling effect upon patient care and physician participation in Medicare and Medicaid
- Shift of home health care costs from Medicare Part A to Part B
- Funding for medical education and medical schools
- Medicaid reform and Medicaid/Medicare reimbursement policies for low income senior "dual eligibles"

In addition to concerns relative to Medicare/Medicaid we have been very active in promoting the following health, safety, and patient legislation:

- Patient protection
- Support for medical education and research
- Public health measures
- Liability reform
- Provider-sponsored networks

Recognizing that we had an extensive and formidable agenda, and the need for direct contact with Kentucky's Congressional Delegation, officers of KMA and KEMPAC conducted a three-day Washington visitation on June 2-4, 1997. We were able to discuss our concerns with every member of the Kentucky Congressional Delegation and their senior staffs. Our major purpose was to express strong support for patient protection and liability reform, and oppose HCFA's efforts to sharply reduce Medicare funding for physician reimbursement by relying upon flawed data and studies.

The KMA Delegation visited Senators Ford and McConnell, and Congressmen Whitfield, Lewis, Northup, Bunning, Rogers, and Baesler. In each case we were able to spend considerable time with each member of the Congressional Delegation and staff. While supportive of medicine's concerns, only members of legislative committees negotiating the final budget process



have direction over such fiscal matters as Medicare, funding for health issues, and medical education. The KMA Delegation strongly supported patient protection legislation and recommended that the Kentucky Congressional Delegation support efforts to include patient protection in any budget reconciliation proposal. Physician payment issues were a major topic of discussion. The KMA pointed out that physician spending is already more tightly constrained than any other sector of the health industry. The Senate Finance Committee draft calls for physician cuts of \$5.3 billion over five years primarily by revising the physician payment update formula. KMA urged the Congressional Delegation to support keeping the Medicare physician conversion factor at \$37.13 in 1998 and a physician update formula that covers practice costs increases beyond the physician's control. In addition, KMA discussed in detail the proposed new resource-based practice expense (RBPE) values being developed by HCFA. The underlying data and methodology being used by HCFA is invalid. AMA urged Congress to extend the RBPE implementation date one year to January 1, 1999.

During our visitations, we urged support for increased emphasis upon provider-sponsored networks and standards that allow flexibility in ownership and management. We specifically discussed KMA's major priority, tort reform, and asked for their support for a provision in the House Ways and Means and Commerce Committees to limit noneconomic damages to \$250,000. According to the Congressional Budget Office, savings incurred would exceed \$600 million in a ten-year period. These savings could be used to extend patient care instead of funding attorney fees and insurance premiums.

During the visitation, we received an excellent briefing from members of the AMA lobbying team at AMA headquarters. The AMA does an excellent job for physicians under extremely trying circumstances. At a time when voters are demanding a balanced budget and reductions in federal taxes, and when the predominance of "savings" can be readily obtained from entitlements, provider-based reimbursement programs make for an easy target. AMA's job isn't made easier by the fact that 56% of American physicians choose not to belong and refuse to participate and fund federation political and legislative activities. Secondly, continued lobbying by single-issue specialty and subspecialty groups who represent relatively narrow views may become medicine's "Achilles' heel." Government and politicians always seek "to divide and conquer," especially when confronted by powerful groups with divergent views. Thirdly, the growth of managed care and development of physician entities have created additional division within the ranks. Despite chinks in medicine's armor, created by relatively few individual medical groups, the AMA remains a highly respected organization in Washington and maintains and sustains one of America's finest lobbying efforts.

On behalf of the Key Contacts for our Kentucky Senators and Representatives, I want to thank the Board of Trustees and House of Delegates for their continued support and interest in the legislative arena. In addition, it is a pleasure to work with Kentucky's Congressional Delegation. Every single one of them, along with their staff, are extremely accessible and helpful. All of us appreciate the work they do on behalf of the Commonwealth and its citizens.

Donald C. Barton, MD
Chairman

Report of the Committee on Professional Liability Insurance

The Committee on Professional Liability Insurance is composed of the KMA Executive Committee and the Chair of the KMA Committee on State Legislative Activities. The committee did not meet during the 1996-1997 year.

The committee participated in a number of activities throughout the year designed to implement much needed tort reform. Members of the committee, along with members of the Committee on National Legislative Activities, traveled to Washington, DC, to meet with Kentucky's Congressional Delegation. Much of the discussion centered around the need for tort reform on a national level. While there seems to be growing support for such reforms, some members of Congress, along with the Clinton Administration, are opposed to their implementation.

The Senate Majority Leader has indicated that tort reform is a priority for the Congress, even if such reforms can only be achieved one piece at a time. This commitment comes after the Senate failed to get a veto proof majority to pass comprehensive legislation dealing with tort reform. One study has

indicated that in 1995 the industry spent \$464 million defending physicians against meritless claims. It is believed that such reforms cannot be achieved without educating the public on the costs of defensive medicine in the health care system.

On the state level, there was no regular session of the Kentucky legislature held during the year. There was a special session on reforming the workers compensation system, which may show potential for reforms in the general liability arena. Such reforms, however, cannot be implemented until the Kentucky Constitution is amended. It continues to be the policy of the committee to work for a constitutional amendment to allow for liability reform in the state, and we will be working diligently next year to achieve that goal when the legislature meets in regular session beginning in January 1998.

Wally O. Montgomery, MD
Chair

Report of the Committee on Care of the Elderly

The Committee on Care of the Elderly continued its efforts this year to serve as an advocate for the profession and the state's elderly population relating to medical concerns, to serve as a liaison with elderly representative groups and related agencies, and to provide an educational forum on geriatric issues for new physicians and other principals involved with this significant part of our population.

This year the culmination of the committee's work was a special seminar held in April to consider the current medical needs of the aging population, to address how those needs are currently being met, and to postulate future needs and trends. There are currently a large number of elderly individuals, with this population growing steadily, and the elderly segment has become, and will continue to be, more dependent on governmental services. As elderly people live productively much longer, there needs to be an overall societal adjustment. Managed care will likely continue to grow in Kentucky and is being proposed for inclusion in the Medicaid program, as well as in Medicare. Issues of concern are the need for continuing availability of supplemental health insurance for Medicare, choosing a managed care vehicle, and purchasing a long-term care policy, as well as other medical and social needs that must be in place and possibly enhanced.

To directly relate to these concerns, representatives of various organizations were in attendance at the seminar and exchanged information with the committee. Presenters included Ms Karen Doyle, Department of Medicaid Services of Kentucky; Ms Billie Halsey, AdminiStar (Medicare); and Mr Jerry Whitley, Director of Aging Services for the Commonwealth. Also in attendance were Mr Laurel True, Kentucky Chapter, AARP, and James G. O'Brien, MD, UL Family and Community Medicine.

The Medicare representative noted that Medicare expenditures have steadily increased through the years, as has the percentage of the elderly population. Also growing is the disabled population, although not as rapidly as the overall Medicare-eligible group. While hospital care has been reduced for this population, home health care, hospice, and other service needs have risen following the trend for outpatient care.

By the year 2001, it is predicted that approximately 50% of all Medicare recipients will be enrolled in HMOs. Currently, those who choose HMOs are healthy patients whose incentives for HMO choice are cost as well as emphasis on preventative care.

A current trend being followed by Medicare has been use of the concept of "disease management." Medicare has identified three chronic diseases — diabetes, COPD, and congestive heart failure — which have been targeted for disease management. Medicare is also working on trying to improve access to primary care, availability of care, and preventative medicine.

Medicare feels that disease management will be a necessity in the future rather than an option. The goal will be to gain familiarity with the patient and attempt to determine underlying causes of disease rather than treating only symptoms. Efforts will be made to increase knowledge by health professionals of patients' habits and lifestyles and attempt to modify these as preventative measures.

The Medicaid representative indicated that the effort to develop and operate the Medicaid managed care or partnership program continues. A part of this effort has been to completely identify and better coordinate all services so that duplication and overlapping of administrative costs can be reduced. This effort has been termed Project Care 2000, which is focused on five special

study areas: Single Point of Entry, Service Evaluation, Consumer Empowerment, Resource Development, and Finance. In addition to coordinating efforts in reducing required Medicaid services, this effort will also include a close address of appropriate eligibility levels for Medicaid recipients.

The Committee on Care of the Elderly learned at this meeting that the state of Kentucky operates or has the potential to conduct a wide array of services which are currently overseen by the Department for Aging Services of the Commonwealth. The representative of this department provided some interesting and informative data which gave a clear picture of the needs of Kentucky's elderly population.

In Kentucky, 19.6% of the population is 60 years or older and at or below the poverty level. Of these elderly persons, 45% live in rural areas with limited access to care, and 75% of this population have difficulty with activities of daily living.

In the 60-year and older group, one in ten report a disability. In the 85-year and older group, two-thirds report disabilities that interfere with daily living, and in the 95-year and older group, 85% have some type of disability. In Kentucky, there are now over 100 persons who are 100 years of age or older who receive state-provided home care. Currently the Division of Aging provides a number of supportive services which include telephone checks, legal aid, transportation, advocacy, ombudsman services for long-term care, and coordination of home health care. Also available are adult day care, which is provided through approximately 50 adult care centers in the state, and a limited program for personal care attendants for elderly individuals who have suffered a lost limb.

According to the representative of the Division of Aging, the elderly have a number of needs which are not currently being met. These include inadequate funding for elderly programs where funding levels have not kept pace with the increasing need in terms of numbers of needy elderly, as well as depth of service, alternatives to institutional care, and transportation services.

There is also the emerging trend of a two-generation elderly population, which consists of those in the 60- to 80-year-old group and the 85-plus-year-old group. The 85-plus-year-old group is generally more financially needy than those 60 to 85 years old.

Additional factors which will increase elderly care needs, in addition to the growing elderly population, are the impact of baby boomers on medical care demands; the situation of changing families where there are more single parents; and a continued increase in divorce and remarriage which results in increased blended families; as well as overall health care allocation. Because the elderly population is increasing, the health care dollar is consistently being absorbed to a greater degree by the older population. It is logical that government spending will likely be rationed to this group in some manner which will necessitate the assumption of more responsibility for the elderly by the elderly for their own care.

A representative for the American Association of Retired Persons identified care concerns of older people, which consisted of more emphasis on prevention of chronic disease; better care management of elderly patients; and access to primary care, which is a particular concern in rural areas.

In summary, the participants in the seminar concluded that the major issues confronting elderly care now and in the future will be preserving the quality of care rendered, assuring transportation and accessibility of services, assisted living services, end-of-life issues, and better coordination of aging services by all participating care providers. The seminar provided some extremely helpful information, some provocative analysis of care needs, and a thoughtful dialogue which was quite beneficial to representatives of various agencies, the AARP and committee members, each of whom is involved indirectly in elderly patient care. As the committee's work continues, it will attempt to disseminate more information on coordinated efforts for the benefit of all physicians.

S. Philip Greiver, MD
Chair

Report of the Public Education Committee

The Public Education Committee has several ongoing programs and projects to bridge the relationship between patients and physicians. In addition, we assist members in their day-to-day communications with patients, public

policy officials, and legislators who utilize medical care or develop policy. Committee programs include:

- The *MediScope* which is the "flagship" of the committee's efforts
- "I Can Be Safe" Booklets — A program in collaboration with the KMA Alliance
- KMA Children's Activity Booklet
- KMA Membership Video
- KMA home page on the Internet
- Pre-legislative Conferences

Essentially, the committee's primary charge is to foster physician/patient relationships, inform the public of ongoing medical and health knowledge, and educate them as to the effect of politics and legislation on patient care. We continue to work closely with our PR Consultant, Mr Glen Bastin, on new innovative, as well as ongoing, projects.

During the year we approved several important projects which fall within the committee's charge. Mrs Ruth Ryan, 1996-97 President of the Alliance, presented a proposal to fund a young children's project to the committee. Recognizing the excellent talents and hard work of the Alliance, the committee agreed at one of its original meetings to establish an "Alliance Grant" on a yearly basis to permit the Alliance to present a project which meets criteria established and fosters the committee's work and goals. In 1997 the committee granted the Alliance \$2,000, plus mailing costs, to purchase books from the AMA Alliance. The booklets, entitled, "I Can Be Safe," have been distributed to various schools which made requests. A similar project was carried out last year. That booklet was entitled, "I Can Choose."

Our PR consultant is in the process of developing a Children's Activity Booklet promoting health and wellness. The committee believes that it can produce a higher quality book at less cost than we presently pay the AMA Alliance. Our book will also carry the KMA and KMAA logos which should help promote the profession and the respective associations within the Commonwealth.

The committee also approved a grant of \$7,500 to the KMA membership department to produce and film a "membership" video. KMA produced a similar video approximately seven years ago and an updated video is needed. The video will be finalized in time to be shown to the 1997 House of Delegates on Wednesday evening during the Public Education Committee's oral report.

When the House of Delegates established the Public Education Committee it was obvious that most members had little knowledge or awareness of KMA's ongoing public education efforts. The committee is continually aware of the need to keep members posted on the committee and KMA's PR efforts. The committee receives \$25 annually from each member so we believe a relatively small portion of committee funding to keep members informed is an excellent investment.

Recognizing the effectiveness of *MediScope*, the committee has agreed to increase the number of *MediScopes* mailed to each KMA member from 10 to 25 copies. In addition, we are participating in a new KMA membership project by financing the printing and mailing, along with an introductory letter, of one copy of the newsletter to each KMA nonmember. We believe the KMA membership department can make effective use of this tool. We continue to encourage more physicians to order additional copies of *MediScope* for patients.

Another project which has been delayed because of unavoidable glitches, involves establishing a KMA home page on the Internet. The committee's Internet site will be devoted to patients and their health and medical needs. We hope to have current medical news, children's literature, medical information, and the *MediScope* on the home page "on line" in the near future.

A primary component of KMA's success during the 1996 Kentucky General Assembly was the 1996 Pre-legislative Conferences sponsored by the Public Education Committee, Committee on State Legislative Activities, and KEMPAC. The committee has once again approved co-sponsorship of Pre-legislative Conferences in the 15 trustee districts. Staff will be working with the legislative and KEMPAC chairs, along with individual trustees to schedule meetings in each KMA trustee district in late September, October, and early November. As State Legislative Chair Wally O. Montgomery, MD, has noted, we have an enormous agenda in 1998, so we want to prepare the membership and the public for legislation of interest to patients.

The committee is constantly seeking new and innovative programs that are effective, provide a service to our patients and the profession, and meet



the guidelines established by the Board of Trustees. The committee is particularly interested in the activities of the Committee on Maternal and Neonatal Health and the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan. We will seek to assist these committees in their educational and legislative efforts, particularly as it relates to sexually transmitted diseases and life skills. We believe the committee can serve as a catalyst for their ideas and efforts and will be volunteering committee services, grants, and support.

While the Public Education Committee is doing an excellent job in promoting the physician/patient relationship, it has made us increasingly aware of the other diligent and hard-working KMA committees that work quietly day in and day out with the youth, elderly, athletes, the abused, students, educational institutions, legislators and government, along with consumer groups on health and safety issues, indigent patients who need free medical care, and in numerous other ways to improve the lives and lifestyle of our citizens.

On behalf of committee members, we thank the Board of Trustees and House of Delegates for allowing us to serve. We look forward to the continuing cooperation and support of the membership in the coming year. We especially encourage members who have patient/public oriented ideas for projects or programs to refer them to the Public Education Committee for consideration.

Preston P. Nunnelley, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Committee on State Legislative Activities

The Committee on State Legislative Activities met on one occasion during the year. The committee reviewed the various procedures and policies KMA adheres to during the General Assembly. We continue to look for better and more effective ways to communicate with members and other groups who support our positions. Providing updated and accurate information is the hallmark of a well thought out legislative effort and one to which we ascribe. During the meeting, the committee reviewed the various communication mechanisms the Association and the Legislative Quick Action Committee utilize with KMA membership during legislative sessions:

- a. **Legislative Bulletin.** Approximately 7,000 are mailed weekly to:
 - KMA members
 - Alliance members
 - Kentucky Medical Group Management Association members
 - Other appropriate individuals
- b. **Fax.** Bulletins are faxed weekly to approximately 700 KMA members who provide their fax numbers. This is an area we would like to improve upon in order to expedite communications and expand physician legislative contact speed and expertise.
- c. **KMA Journal.** Legislative issues are published monthly in the *Journal* under the topic "Monitoring Medicine." While we attempt to utilize the *Journal* as much as possible in our legislative effort, due to printer deadlines its use is limited.
- d. **E-mail.** E-mail remains in the investigative process as it relates to the KMA legislative communication effort. We would give consideration to "E-mailing" the *Legislative Bulletin* if there is a demonstrated need and members indicate they would utilize the E-mail process.
- e. **Key Contact System.** While we still maintain and utilize a Key Contact System, several years ago we decided to involve every physician in the legislative effort by mailing the weekly *Legislative Bulletin* to all KMA members. This system basically makes all physicians Key Contacts, but still assigns one or more individual local physicians to each legislator.
- f. **Phone Bank.** KMA's phone bank is twofold. One phone bank is operated by KMA staff in coordination with individual county Alliance chapters. In addition, the Fayette County Medical Society Alliance has been very generous by operating a phone bank on a statewide level when necessary and when activated.
- g. **Legislative Handbook.** The 1998 *Legislative Handbook* will be provided to each KMA member. The handbook provides pictures and biographical information of each state and national legislator. In addition, appropriate legislative information on KMA's positions and background data to assist

in the lobbying and contact effort is included.

The primary purpose of the 1997 committee meeting was to review Board of Trustees referrals from the 1996 House of Delegates:

Resolution 96-102 — New Kentucky Medical School

The status of the proposed osteopathy school in Pikeville was reviewed. KMA will oppose any state funding for this purpose.

Resolution 96-105 — "Gag" and "Hold Harmless" Clauses in Managed Care Contracts

KMA introduced legislation in 1996 to accomplish this objective which is included in the 1998 version of KMA's Patient Protection Act and in the Attorney General's proposal.

Resolution 96-110 — Physician/ARNP Collaborative Agreements

KMA opposes expansion of ARNP practice. The Association encourages individualized collaborative agreements between the physician and ARNP rather than "blanket" authorization by the collaborating physician to ARNPs for prescriptive privileges. The Board of Medical Licensure is in the process of drafting guidelines or regulations to assist physicians who chose to collaborate with ARNPs.

Resolution 96-111 — Licensure for Telemedicine

The Kentucky Board of Medical Licensure has formed a task force to make recommendations in this area and KMA has representation on the task force.

Resolution 96-114 — Patient Protection

KMA will either support or introduce an expanded version of the 1996 Patient Protection Act.

Resolution 96-117 — AMA-CPT Coding

KMA supports the statewide use of AMA-CPT coding by insurance companies and legislation will be prepared to address this objective.

Resolution 96-127 — Availability of Laboratory Services

KMA leadership met with the Commissioner of Insurance and will, if necessary, seek to address this problem through legislation in 1998.

Patient Protection/Point of Service/Gag Rules

The 1995 Resolution H, 1996 Resolution 96-114, and 1996 Senate Bill 365 were discussed for comparison. The Attorney General of Kentucky has proposed legislation which mirrors KMA proposals. However, the Attorney General does not believe that "point of service," which KMA supports, is pertinent to this legislation, so consequently, KMA will introduce that proposal separately.

Nonphysician Practitioners

Nonphysician practitioners continue their efforts to broaden their scope of practice. We can expect several groups to present various legislative proposals relating to expansion of practice, prescribing drugs, and other encroachments upon the practice of medicine. Practice expansion by nonphysician practitioners is expected to be a major issue in 1998.

The 1997-98 Kentucky General Assembly

Recent changes in legislative leadership and how these changes affect medical issues are a major concern of the committee. The growth in numbers by the Republican party in Kentucky is particularly evident in the Kentucky Senate where Republicans are outnumbered only 20-18 by the Democrats. Many of us recall a time when the count was 31-7. While the Governor and the majority of House members are Democrats, the majority party will be forced more and more to deal with an increasing vocal minority. This aspect was fully demonstrated in the leadership races in the Senate during the reorganization session in January and in the Special Session on higher education.

Special Sessions of the Kentucky General Assembly

While the Kentucky General Assembly does not meet annually, Special Sessions of the General Assembly are occurring on a more frequent basis. In late 1996 the Governor called the General Assembly into session to resolve the Workers Compensation crisis in Kentucky. In a rambunctious session, the Governor confronted trial lawyers, coal miners, and labor, and achieved a tremendous success for business and tax payers of Kentucky by passing long-needed reform of the Workers Compensation program. The KMA strongly supported the Governor's proposal, and for the first time Workers Compensation reform.

In the Spring of 1997 Governor Patton took on an even stronger foe, the

University of Kentucky and its supporters. The Governor once again succeeded in his reform efforts and the majority of his proposals related to higher education were adopted. Political pundits are beginning to question whether the Governor can continue to sustain his popularity in the wake of the reforms enacted which dramatically affect some very powerful groups and individuals. Many of the groups most affected by the Special Sessions were some of his strongest supporters. It will be interesting to see how this scenario plays out in the 1998 General Assembly and the next Gubernatorial campaign.

Medicaid

As a result of KMA's legislative efforts in 1996, KMA House of Delegates action to resolve the provider tax issue, Health Care Reform legislation, and refinement of Medicaid reimbursement and settlement of the lawsuit, we thought the thornier issues related to Medicaid had been resolved. However, with impending Regional Medicaid Partnerships in the eight districts in Kentucky and implementation of managed care concepts for the first time in Medicaid, you may expect considerable fireworks in the 1998 Session. In addition, the General Assembly will be grappling with "Welfare to Work" programs required by the federal government, which will generate problems for government and health care providers.

Other Issues

The Governor's concern with alleged prescription abuse by physicians is of great concern to the Legislative Committee. The Attorney General has appointed a task force to make recommendations to the 1998 General Assembly and KMA is a well represented on the study group. We have met with the Governor, Lt Governor, and scheduled several meetings with the Secretary of Health Services to review this matter and seek supportive data before seeking legislative or regulatory solutions to the problem.

The issue of physician data banks with attention given to legislation adopted in Massachusetts is a major topic in legislative circles. We can expect legislation to be introduced and strongly supported by consumer and news media groups.

Interest in Certificate of Need continues to mount in the halls of the General Assembly and within regulatory agencies. With the passage of legislation in 1996 which established a \$1.5 million threshold for physicians offices before they are required to obtain a CON prior to purchasing major medical equipment, hospitals and others feel threatened and are urging state government to sharply define "doctors' offices." We believe this is an attempt by hospitals and others to reduce competition. KMA will continue, as stated in testimony to the Interim Health and Welfare Committee, to oppose the placement of physicians offices under CON or have the General Assembly define physicians' offices.

Safety and health issues remain a priority to KMA. We expect to support boat safety, increased penalties for drunk drivers, stronger vehicle safety and helmet laws, legislation to forbid children under 18 from riding in open pickup trucks, and other measures as directed by the KMA House of Delegates. In addition, we will continue to support measures to reduce and eventually stop the sale of tobacco to children.

The 1998 Session promises to be very explosive, and particularly dangerous to the medical profession and the patients we serve. Continuing inroads by nonphysician practitioners; public appetite for alternative health care and nontraditional health practitioners' willingness to fill that void; growth of government insurance programs, especially Medicaid, which is expected to be expanded by Congress to include practically all uninsured children; government intervention and control; and last, but not least, the health insurers, including the HMOs who continue to wage their "managed care for everybody," contribute to a climate not conducive to good health/medical legislation. We may be inundated by both individual and joint efforts by the above listed groups, and our survival will depend upon how well physicians respond to "the call." Let me assure you that your legislative committee, KMA leadership, and staff will do everything within their power to hold the line and stave off the assaults that are sure to come — but we can't go it alone.

The KMA legislative committee is scheduling several programs in preparation for the 1998 General Assembly. Once again, the Public Education Committee, Committee on State Legislative Activities, and KEMPAC are uniting to hold regional Pre-legislative Conferences throughout Kentucky. KMA leadership and lobbying staff will be participating in these programs and bringing them to the local physician communities for input. In addition, we

plan to hold a Legislative Seminar in Frankfort in early January. Everyone will be invited.

During the 1998 Session of the Kentucky General Assembly we recommend that KMA operate under the following policies and procedures:

1. All state legislative proposals are to be coordinated by and channeled through the Chair of the Committee on State Legislative Activities.
2. The composition, authority, and function of the Quick Action Committee are retained.
3. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chair of the Committee on State Legislative Activities and the KMA Quick Action Committee.
4. KMA lobbyists in Frankfort during the Kentucky General Assembly are responsible only to immediate superiors and not to individual members of the Association. Any complaint relative to the state legislative program or its operation should be directed to the Committee on State Legislative Activities Chair and not to staff.

On behalf of the Committee on State Legislative Activities, we appreciate membership participation and interest in the state legislative effort. We look forward to your continuing support and input as we prepare for the difficult days ahead.

Wally O. Montgomery, MD
Chair

RECOMMENDATIONS:

1. All state legislative proposals are to be coordinated by and channeled through the Chair of the Committee on State Legislative Activities.
2. The composition, authority, and function of the Quick Action Committee are retained.
3. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chair of the Committee on State Legislative Activities and the KMA Quick Action Committee.
4. KMA lobbyists in Frankfort during the Kentucky General Assembly are responsible only to immediate superiors and not to individual members of the Association. Any complaint relative to the state legislative program or its operation should be directed to the Committee on State Legislative Activities Chair and not to staff.

Recommendations, Reference Committee C:

Reference Committee C reviewed the report of the Committee on State Legislative Activities and its four Recommendations concerning operational procedures to be followed during the 1998 session of the Kentucky General Assembly. Reference Committee C would like to express its appreciation to Doctor Montgomery for his diligent efforts on this committee and continued work in the future.

The committee recommends the Report of the Committee on State Legislative Activities and its Recommendations be adopted.

RESOLUTION 97-103

Mandatory HIV Education for Physicians Warren County Medical Society

WHEREAS, the increasing complexity of treating HIV disease is now widely nationally recognized, and it is no longer felt appropriate by any national medical organization that physicians without a deep interest and continuing experience in treating this disease undertake primary care of these patients; and

WHEREAS, the universal HIV education currently mandated for receiving or renewal of medical licenses in Kentucky imposes a burden of record-keeping on both the Kentucky Board of Medical Licensure and individual physicians; and

WHEREAS, the regulation imposes utilization of resources of time and money that could be allocated elsewhere to improve patient care; now, therefore, be it

RESOLVED, that in the best interest of patients and the medical care system, the KMA request that the Kentucky General Assembly repeal the no longer appropriate requirement for universal HIV physician education, which is too little to help those who are interested in treatment of the disease, and of



no use to great numbers of physicians who would not be acting in a primary care capacity to these patients.

RESOLUTION 97-120

Mandatory Domestic Violence Educational Requirements for Primary Care Physicians Warren County Medical Society

WHEREAS, medical information in diagnosis and treatment of diseases is increasing at an almost exponential rate; and

WHEREAS, each individual physician knows in which areas of study he is weakest; and

WHEREAS, the state is requiring physicians to spend more and more time studying specific entities such as domestic violence, making it increasingly difficult for the physician to utilize study times effectively; and

WHEREAS, this decrease in effectiveness of educational time will have a negative impact on patient care; now, therefore, be it

RESOLVED, that in the best interest of all of the patients and the medical care system of Kentucky, the KMA request that the legislature repeal its mandatory continuing medical education requirements concerning domestic violence.

RESOLUTION 97-126

Mandatory Domestic Violence Education for Primary Care Physicians Henderson County Medical Society

WHEREAS, as informed citizens, the tragic increase in domestic violence is well known to Kentucky primary care physicians; and

WHEREAS, the subject of domestic violence is frequently addressed in the literature to which we subscribe; and

WHEREAS, the Kentucky Medical Association Alliance has gone to great effort to educate Kentucky physicians and the public on the subject of domestic violence; and

WHEREAS, the problem of domestic violence in the Commonwealth of Kentucky is not that Kentucky physicians do not recognize domestic violence or properly treat the victims, but that it exists and is on the increase in our society; and

WHEREAS, the imposition of an additional mandatory CME would place an increased burden of record-keeping on the Kentucky Board of Medical Licensure; now, therefore, be it

RESOLVED, that in the best interest of the victims of domestic violence in the Commonwealth of Kentucky and in the best interest of our medical system, attention be directed to the behavior and societal deficiencies that have generated the increase in domestic violence; and be it further

RESOLVED, that the Kentucky Medical Association request that the Kentucky General Assembly repeal the mandatory domestic violence education requirement from the mandatory CME requirement already demanded of Kentucky primary care physicians.

Recommendations, Reference Committee C:

Mr. Speaker, Reference Committee C has considered Resolution 103, Mandatory HIV Education for Physicians, submitted by the Warren County Medical Society; Resolution 120, Mandatory Domestic Violence Educational Requirements for Primary Care Physicians, submitted by the Warren County Medical Society; and Resolution 126, Mandatory Domestic Violence Education for Primary Care Physicians, submitted by the Henderson County Medical Society. After much discussion and considering the similar nature of these resolutions, this committee chose to address the three resolutions as one and offers the following substitute resolution:

RESOLVED, that the Kentucky Medical Association reaffirm its support of continuing medical education and also reaffirm its opposition to mandated "disease-specific" continuing medical education for Kentucky physicians and urges repeal of any and all statutory requirements for continuing medical education of specific diseases.

Reference Committee C recommends the adoption of the substitute resolution in lieu of Resolutions 103, 120 and 126.

An amendment was offered on the floor of the House to add "topic-specific" to line 26. The substitute resolution would then read:

RESOLVED, that the Kentucky Medical Association reaffirm its support of continuing medical education and also reaffirm its opposition to mandated "disease- and topic-specific" continuing medical education for Kentucky physicians and urges repeal of any and all statutory requirements for continuing medical education of specific diseases.

The reference committee substitute was adopted as amended from the floor in lieu of Resolutions 103, 120, and 126.

RESOLUTION 97-108

Medicare Audits Jefferson County Medical Society

WHEREAS, reports have been received that Medicare audits of Kentucky physicians' offices have been conducted by persons without adequate understanding of medical practice; and

WHEREAS, these personnel have been without adequate medical supervision or guidance due to the vacancy of the position of Medicare Part B Medical Director; and

WHEREAS, recent reports indicate a likelihood that physicians who receive negative audit reports may be subject to severe penalties or prosecution for alleged fraud and abuse; and

WHEREAS, the current situation in Kentucky could result in competent, honest, and well-intended physicians facing the consequences of inappropriately negative audit reports; now, therefore, be it

RESOLVED, that the Kentucky Medical Association enlist the support of Kentucky's elected federal representatives and regulatory agencies to ensure that Medicare audits are conducted competently, by personnel with adequate medical training and understanding, and with appropriate medical supervision.

Recommendations, Reference Committee C:

Reference Committee C next considered Resolution 108, Medicare Audits, submitted by Jefferson Medical Society, and recommends Resolution 108 be adopted.

RESOLUTION 97-131

Physician Participation in Capital Punishment Board of Trustees

WHEREAS, legislation has been introduced by the Kentucky General Assembly relating to the death penalty to allow those presently sentenced to death to choose death by either electrocution or lethal injection; and

WHEREAS, such legislation will propose that all future condemned prisoners be executed by lethal injection; now, therefore, be it

RESOLVED, that the Kentucky Medical Association as an entity neither supports nor opposes the death penalty; and be it further

RESOLVED, that an individual physician's personal opinion on capital punishment is the personal moral decision of the individual; and be it further

RESOLVED, that in accordance with AMA current ethical opinions which have been adopted by the Kentucky Board of Medical Licensure as conditions of licensure, physician participation in executions, except to certify cause of death, is a serious violation of medical ethics; and be it further

RESOLVED, that the Kentucky Medical Association oppose any legislation or regulation requiring physician participation in execution except to certify death.

Recommendations, Reference Committee C:

Reference Committee C reviewed Resolution 131, Physician Participation in Capital Punishment, submitted by the Board of Trustees and it was noted that a physician may not only be required to certify the cause of death but also to pronounce death. The committee recommends amendment of the third resolved by the addition of the phrase "pronounce and/or," so that the amended resolved would read:

RESOLVED, that in accordance with AMA current ethical opinions which have been adopted by the Kentucky Board of Medical Licensure as conditions of licensure, physician participation in executions, except to pronounce and/or certify cause of death, is a serious violation of medical ethics;

Reference Committee C recommends the adoption of the Resolution 131 as amended.

Harry W. Carloss, MD, Paducah, presented a recommendation of the Board of Trustees that the added wording be deleted in order to comply with the AMA Code of Ethics. To remain in compliance with the AMA Code of Ethics, J. Gregory Cooper, MD, Cynthiana, further suggested that the phrase "provided that the condemned has been declared dead by another person" be inserted after "cause of death." The Resolved would then read:

RESOLVED, that in accordance with AMA current ethical opinions which have been adopted by the Kentucky Board of Medical Licensure as conditions of licensure, physician participation in executions, except to certify cause of death, provided that the condemned has been declared dead by another person, is a serious violation of medical ethics;

Resolution 97-131 was adopted as amended on the floor of the House.

RESOLUTION 97-132

Fraud and Abuse

Board of Trustees

WHEREAS, there is a perception that fraud and abuse in the health care system constitute a significant cost to the system; and

WHEREAS, this perception has led to the enactment of legislation in an effort to investigate and prosecute alleged fraud and abuse; and

WHEREAS, federal government agencies are authorized to use money received through settling fraud and abuse cases to investigate additional cases in the health care system; and

WHEREAS, it is estimated that for every dollar spent on investigating fraud and abuse, federal government agencies receive \$23 in settlements; and

WHEREAS, it is estimated that 4,700 of the nation's 6,300 hospitals are responding to investigations, leading the American Hospital Association to ask for a six-month moratorium on all such investigations; and

WHEREAS, the FBI Fraud Unit conducted 365 health-related investigations in 1991, compared to 2,000 investigations in 1996; and

WHEREAS, since the enactment of the Health Insurance Portability and Accountability Act, the Department of Health and Human Services Office of the Inspector General has closed nearly \$1 billion in settlements; and

WHEREAS, investigative techniques used by law enforcement authorities have raised concerns regarding physician and patient rights to privacy and due process; and

WHEREAS, new legislation is being proposed that would further expand fraud and abuse laws against physicians, including statutory language that would allow for the prosecution of inadvertent errors by physicians; now, therefore, be it

RESOLVED, that the KMA support reasonable efforts to locate, investigate, and prosecute instances of willful fraud and abuse intentionally committed by any health care provider; and be it further

RESOLVED, that physicians and their staffs be encouraged to become informed about the implications of federal and state fraud and abuse laws by availing themselves of educational opportunities planned by KMA and other organizations which seek to explain physician obligations and individual rights and responsibilities under the law; and be it further

RESOLVED, that KMA support efforts by the American Medical Association to encourage Congress to implement appropriate amendments to federal laws which would prevent inappropriate investigations and prosecution of unintentional errors which could be easily resolved through an educational process.

Recommendations, Reference Committee C:

Resolution 132 — Fraud and Abuse (Board of Trustees)

Reference Committee C reviewed Resolution 132, Fraud and Abuse, submitted by the Board of Trustees, and recommends amendment of the third Resolved by the addition of the word "all" to read as follows:

RESOLVED, that KMA support all efforts by the American Medical Association to encourage Congress to implement appropriate amendments to federal laws which would prevent inappropriate investigations and prosecution of unintentional errors which could be easily resolved through an educational process.

Reference Committee C recommends adoption of Resolution 132 as amended.

RESOLUTION 97-133

Gag Clauses

Board of Trustees

WHEREAS, so-called gag clauses prohibit physicians from discussing certain treatment options with patients because the health plan either does not cover the options or the "plan" considers the options too expensive; and

WHEREAS, gag clauses permit insurers to retaliate against a physician for engaging in what has been traditionally considered "protected" communication between the patient and physician; and

WHEREAS, the Kentucky Medical Association proposed legislation which failed to pass during the 1996 Kentucky General Assembly which would have prohibited gag clauses which intervene in the patient/physician relationship; and

WHEREAS, Kentucky's Attorney General and members of the Kentucky General Assembly have proposed extensive patient protection measures which include prohibitions against gag clauses; and

WHEREAS, federal legislation (House Resolution 586) to prohibit gag clauses has garnered 289 sponsors, including five of Kentucky's six Congressmen; and

WHEREAS, gag clauses are prohibited in Medicare and other federal government contracts; and

WHEREAS, 18 states have enacted legislation specifically prohibiting gag clauses; and

WHEREAS, despite protestations by Insurance Companies and HMOs that these contracts no longer exist in Kentucky, AMA recently reported that it has discovered a contract in Kentucky which includes such provisions; now, therefore, be it

RESOLVED, that the KMA House of Delegates commends the five Kentucky Congressmen who co-sponsored H.R. 586, Kentucky's Attorney General, members of the Patton/Henry Administration, and the Kentucky General Assembly who have supported KMA's efforts to enact patient protection legislation; and be it further

RESOLVED, that KMA proceed with efforts in a Special Session, or the next regular session of the Kentucky General Assembly, to enact patient protection legislation which has been designated by this House of Delegates as a major priority; and be it further

RESOLVED, that the issue of Gag Clauses be referred to the Kentucky Board of Medical Licensure and the KMA Judicial Council for review to determine the ethics of such contracts and their inherent intervention in the traditional patient/physician relationship.

Recommendations, Reference Committee C:

Reference Committee C reviewed Resolution 133, Gag Clause, submitted by the Board of Trustees. Reference Committee C recommends Resolution 133 be adopted.

Mr. Speaker, Reference Committee C recommends the adoption of the report of Reference Committee C as a whole, as amended.

Mr. Speaker, I wish to personally thank the other members of Reference Committee C who have attempted to assist this House of Delegates in trying to formulate equitable policies on some very worthy but controversial issues. Other members of this committee are: James F. Beattie, Jr, MD, Bowling Green; Robert C. Hughes, MD, Murray; Nicholas R. Jurich, MD, Prestonsburg; Arthur K. Rivard, MD, Danville; and John R. White, MD, Lexington. Reference Committee C would also like to personally thank Pam Wethington for her assistance in preparing this report.

Respectfully submitted,
REFERENCE COMMITTEE C

Lela C. Maynard, MD, Pikeville, Chair
James F. Beattie, Jr, MD, Bowling Green
Robert C. Hughes, MD, Murray
Nicholas R. Jurich, MD, Prestonsburg
Arthur K. Rivard, MD, Danville
John R. White, MD, Lexington

Speaker McClellan called on William Monnig, MD, to present the KEMPAC report.



KEMPAC Report To House of Delegates

September 17, 1997

William B. Monnig, MD, Chairman

Unfortunately, I don't have a lot of good news to report to you tonight concerning KEMPAC. Membership is down significantly from last year — in fact, membership has dropped 173 members, a percentage drop of 20%. If you're looking for an excuse associated with the decline of KEMPAC membership, you might be interested to know that across the nation membership decline is epidemic. According to AMPAC, membership declined 7,731 members in 1997, in terms of percentage that's 17%. KEMPAC Board members recently conducted a "peer to peer" recruitment effort. We personalized and individualized letters to 2,900 of our fellow physicians. Only 70 physicians responded in the affirmative by joining KEMPAC. AMPAC mailed a carbon billing which has produced 46 members. We have also developed a new brochure which is in your packet.

No one seems to understand the rationale for the sudden drop, however, if it continues it could spell big trouble for medicine on both the state and national level. On August 1st the physician provider tax dropped to 1%, down from the initial 2%. We no longer have to deal with the Health Policy Board and all the bureaucratic machinations that group was able to create in a relative short time. Thirdly, we had a significant increase in Medicaid reimbursement, along with a nice \$52 million settlement. Our successes weren't entirely due to physicians' individual articulation of the issues. Being candid, our success to a great extent can be attributed to hard-ball politics, by working and contributing to candidates who share our concerns and philosophies. In 1996 we were able to back up our position by proving in numerous regions in Kentucky that physicians finally recognized that only through political action could they achieve reasonable results from our elected officials. The combined efforts of the Public Education Committee, KEMPAC, and the State Legislative Committee made it possible. The cost probably exceeded a half-million dollars — an insignificant expenditure when compared with repeal of a \$42 million provider tax on an annual basis — and restoration of \$52 million in Medicaid reimbursement.

Individually, physicians give rather sparingly to political campaigns — an average of about \$25 per year. However, collectively, through KEMPAC and AMPAC physicians are a powerful entity. A case in point was Congresswoman Anne Northup's campaign for Congress. KEMPAC/AMPAC contributed \$70,000 to her successful campaign, \$60,000 through independent expenditures.

If we are to truly represent medicine it is incumbent that we lead the way and support the political arm of medicine. In 1998 we will elect a US Senator, 6 of 8 Congressmen, 100 of 100 State Representatives, and 19 of 38 Kentucky Senators. These folks are going to have a significant impact upon our future. Candidates who we recognize as our friends expect financial support, especially at a time when the cost of running for public office is almost prohibitive.

If you are not a KEMPAC member — you ought to be. The KEMPAC table is open outside the House of Delegates. The cost is \$100, and over the long haul, the best \$100 you'll ever spend.

Mr Speaker, this concludes my report. I will be happy to respond to any questions you may have.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE D

K. Thomas Reichard, MD, Louisville, Chair

28. Report of the Committee on Medical Insurance and Prepayment Plans
29. Report of the PRO Advisory Committee
30. Report of the Committee to Investigate Changing Trends in Medicine
31. Report of the Young Physicians Steering Committee
32. Report of the Resident Physicians Section
33. Report of the Medical Student Section
- Report of the KMA Membership Task Force
- Report of the Ad Hoc Committee on Faculty Membership
- Resolution 106 — Dues-Fee Membership for Resident Physicians

(Jefferson County Medical Society)

Resolution 107 — Shifting of Administrative Burdens by Insurance Companies

(Jefferson County Medical Society)

Resolution 115 — Medical Practice Business Expenses

(Jefferson County Medical Society)

Resolution 118 — Alternative Medical Practice

(Kentucky Academy of Family Physicians)

Resolution 123 — Parity for Mental Illness in Medical Benefits Programs

(Kentucky Psychiatric Association)

Resolution 129 — Reaffirmation of Resolution R (1995)

(Fayette County Medical Society)

Resolution 134 — Mandatory Provisions in Health Insurance Policies

(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee D reviewed the following items and recommends they be filed, by consent of the House, without discussion:

28. Report of the Committee on Medical Insurance and Prepayment Plans — filed
 31. Report of the Young Physicians Steering Committee — filed
 32. Report of the Resident Physicians Section — filed
 33. Report of the Medical Student Section — filed
 - Report of the KMA Membership Task Force — filed
 - Report of the Ad Hoc Committee on Faculty Membership — filed
- Reference Committee D would like to express its appreciation to the authors of the reports which have been filed for their time and effort spent in preparing these reports for the House of Delegates.

Mr Speaker, Reference Committee D recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans was appointed to consider problems in plans of third-party payors, serve as primary liaison with carriers for KMA, and speak on behalf of KMA to address problems or suggestions the Association might have.

Given this charge, the committee's general main activity is devoted to overseeing and reviewing rates for the KMA physicians' group insurance plan that is carried by Anthem Blue Cross-Blue Shield. This year the committee fulfilled its routine role. However, this role was complicated by the many dynamics in the insurance industry affecting all Kentuckians. Additionally, physicians were confronted with the specific issues of the insurance problem in the state because of significant changes in the conduct of operations by Anthem Blue Cross-Blue Shield.

In November 1996 Anthem announced its intent to combine its insurance networks and to modify physician reimbursement in these networks. The announcement stated that beginning February 1, 1997, reimbursement for services provided to individuals having traditional coverage would be changed to 154% of Medicare payments, that the PPOs Option 2000 and Option 2000 Advantage would see a modification in reimbursement rates to physicians of 126% of Medicare. Part of these general changes included a revision of state payment areas from three to two, urban and rural. Reimbursement changes would result in an aggregate raise in payments to physicians in rural areas of 3%, with a reduction overall in reimbursement to physicians in urban settings in specific specialties. A part of these changes also included the development of a reference lab network.

Recently (June 30, 1997), Anthem notified physicians of an additional change in the processing of claims for physicians' services to go into effect October 1, 1997. It was announced that reimbursement for services provided through traditional plans would change from 154% to 140% of Medicare, and reimbursement for services provided to HMO Kentucky and HMO Option patients would be changed to 125% of Medicare.

Aside from the effects these changes had through the year on patient accessibility to care and physician participation, these revisions were associated with the larger insurance crisis in Kentucky. As most physicians know, the insurance crisis was occasioned by SB 343 and its earlier counterpart, HB 250. Due to the provisions of these laws, insurance to nonself-insured plans became extremely difficult to obtain because many carriers

quit or discontinued business in the state. As a result, Anthem Blue Cross became the major provider of individual health insurance and is now the sole provider in the market, and the small group insurance area became very restrictive.

To address the insurance crisis in the state, Commissioner of Insurance George Nichols, II, convened two task forces to look at all issues. One task force represented consumers and providers of medical services, and the other task force consisted of individuals representing the insurance industry. The work of the task forces appointed by Commissioner Nichols and standing state legislative committee considerations are worth noting because they defined the specific problems of the insurance crisis. A consensus on resolution of these problems has currently not been achieved, however.

Worthy of note are the demographic characteristics of the Kentucky insurance market. There are 3,789,000 citizens in Kentucky; 530,000 are uninsured; 990,000 are covered by Medicare or Medicaid; 2,269,000 are privately insured. Of this number, 1,135,000 are under self-insurance programs (which constitutes one-half of the private market and are exempt from regulation because of federal law), and 102,000 are insured through "associations."

Since the requirements of SB 343 and its predecessor, HB 250, have gone into effect, 45 companies which previously sold individual coverage have left the Kentucky market, with only two remaining (Anthem Blue Cross-Blue Shield and Kentucky Kare). This drain on Kentucky Kare is consuming that program's reserves at rate that is not sustainable. Anthem has reported a \$60 million loss during a one-year period (unaudited), while Kentucky Kare lost \$30 million in 20 months (verified).

The "reforms" caused by the new laws only affect 40% of the insurance market because self-insured plans (ERISA) and government programs such as Medicare and Medicaid obviously are exempt. A crucial element of reform is modified community rating, which insurers say has made costs, and therefore risks, unpredictable. This, along with a 3% cap on insurance premiums, has effectively closed the market, with the exception of Anthem, as previously noted.

To try to deal with the issue, the Department of Insurance has required any company that sells group insurance after 7/1/96 to also sell individual coverage, but there are few companies remaining to which this applies. Any new company coming into this state is required to sell both group and individual coverage, and companies which left the state are banned from returning for a five-year period. HMOs are now required to have an open enrollment period to accept any person seeking individual coverage.

To date, the task forces appointed by the Commissioner of Insurance have produced consensus in many areas, particularly in regard to guaranteed issue, portability, renewability, and preexisting conditions. These keys are also components of the so-called Kassebaum-Kennedy bill, which has passed Congress and is to go into effect in Kentucky beginning, most likely, in 1998. However, the Kassebaum-Kennedy requirements *do not* apply to persons seeking individual coverage, but only those who are currently or were covered under a group plan.

Currently, the two task forces disagree on the rating methodology, coverage for high-risk individuals, and insurance oversight. The consumer group supports a modified community rating system, which the insurance task force group supports experience or group rating. The consumer group opposes a "high risk pool" operated by the state, feeling that it discriminates against certain individuals, while the insurance group feels that a high-risk pool is the only reasonable method to provide coverage to such individuals. The consumer group feels that oversight of insurance issues should be given by both the Commissioner of Insurance and the Attorney General, who is seen in this regard as a consumer advocate. The insurance group feels that oversight by the Department of Insurance only, is important, feeling it is unfair to attempt regulation of one industry by two separate agencies of government.

The only reasonable resolution to all of these issues appears to be a revision of state law, which will be the subject of a special session of the legislature.

Because of these dynamics, there was no increase in the KMA group premium, and premiums for Delta Dental coverage actually decreased by 6%. This situation, however, resulted from the provisions of the state laws just discussed. It is anticipated that these, as well as all other insurance premiums in the state, will increase significantly if any caps are removed.

As chair, I would like to thank the Board of Trustees for the trust given

the committee to monitor these activities. The committee will continue to oversee these efforts and try to represent KMA's interests where appropriate.

**Donald R. Neel, MD
Chair**

Report of the Young Physicians Steering Committee

The goal of the Young Physicians Section (YPS) is to address special concerns of young physicians and determine ways that medicine can be more responsive to those concerns. The steering committee is charged to facilitate communication and interaction between young physicians with the view to developing leadership potential for doctors in organized medicine. The committee membership is composed of physicians 40 years of age and under, or who have been in practice five years or less.

At the 1996 Annual Meeting, the Young Physicians Steering Committee conducted a luncheon and seminar for all young doctors. The seminar provided a forum for the informal interchange of ideas and issues and opportunity for those present to network with their colleagues. At the meeting, a presentation was made by Stuart Gitlow, MD, MPH, on communications and use of the Internet. Using a large screen interface with Dr Gitlow's personal computer, Internet access was opened and an effective "how-to" presentation was made.

The YPS has scheduled a general meeting in August of this year at the KMA headquarters to solicit further input and participation. At this meeting, activities and future areas of involvement by the committee will be considered, as well as issues to be suggested by the committee for consideration by the KMA House of Delegates, and representation from Kentucky at AMA meetings by young physicians. This should be an informative and helpful meeting conducted in the new KMA offices and, again, collegial networking will be encouraged.

The committee noted with gratification the election of committee member Bruce A. Scott, MD, of Louisville, as the AMA Young Physician Section delegate to the AMA House of Delegates. As the sole slotted YPS delegate to the AMA House, Dr Scott serves in a unique role and, additionally, provides another voice to that body specifically for Kentucky's concerns.

The YPS will again conduct a meeting during the KMA Annual Meeting in 1997, and program topics are currently under development. The committee continues to try to expand its activities, and urges all young physicians to become active in its efforts. As chair, I would like to thank the members of the committee and all others who participated in our events this year.

**W. Ford Threlkeld, MD
Chair**

Report of the Resident Physicians Section

The Resident Physicians Section has been involved in numerous activities at the state and national levels this year. Representatives from residency programs at the University of Louisville, University of Kentucky, Trover Clinic, and St Elizabeth's form the section's Governing Council which meets regularly to discuss matters of interest to residents in Kentucky.

The council met four times this year and has had strong representation at the KMA Annual Meeting as well as the AMA Interim and Annual Meetings.

The 1996 joint Annual Meeting of the KMA Medical Student Section and Resident Physicians Section, held September 27, in Louisville, dealt with "Politics and the Medical Profession." Kentucky State Senator James D. Crase, MD, and Lt Governor Steve Henry, MD, gave students and residents an overview of what is going on in Frankfort that will affect their future practices. Immediate Past Chair of the AMA-MSS Governing Council, James Woody, MD, UK family practice resident and KMA-RPS President-Elect, gave a report on activities taking place at the national level.

The council, at its January meeting, focused on resident membership which has slowly declined both at the KMA and AMA levels in the past several years. As a result of input from council members, several goals were established: (1) streamline membership requirements in counties which have a lengthy application and (2) initiate dues payment (whether one-year and or multi-year) as new residents apply during Orientation. As a result of these recommendations, the council is pleased to report that the Jefferson County Medical Society has condensed its In-Training application to a one-page document and is proposing a one-time application fee for resident



membership. New initiatives were also instituted at St Elizabeth's to enroll every resident upon joining the residency program there. The council wishes to express appreciation to these entities for their support of organized medicine.

New officers were elected in April and tentative plans were made for the upcoming AMA and KMA Annual Meetings. The July 15th meeting reviewed plans for the RPS and MSS Annual Meeting to be held September 16, 1997, and featured reports from the 1997 AMA-RPS Annual Meeting held in Chicago. A resolution concerning the availability of non-latex products for health care workers was submitted by the KMA-RPS and adopted at the AMA-RPS Annual Meeting in June.

In late June, KMA once again participated in the Housestaff Orientations at UK, UL, and St Elizabeth's. Over 110 residents joined the Association through these efforts. We are grateful to those programs which allow KMA and the county societies to participate at Orientations.

As President, I want to thank the individual members of the Governing Council for their attendance and input at the quarterly meetings. On behalf of the council, I also wish to thank the KMA Officers, Board of Trustees, and House of Delegates for their continued support and for giving residents the opportunity to have a voice on issues affecting the future of our profession.

F. Wesley Dunaway, MD
President

Report of the Medical Student Section

The KMA Medical Student Section has been active at the individual chapters at the University of Kentucky and University of Louisville, as well as having strong representation at KMA and AMA meetings. The sixth annual statewide meeting of Kentucky residents and students, held September 27 in Louisville, was well received. Comments from the speakers who dealt with politics and the medical profession initiated a lively discussion from those in attendance.

Presidents from both MSS chapters received Outreach Program Awards at the 1996 AMA Interim Meeting in Atlanta for their recruitment of student members for the AMA. Both chapters did an outstanding job this year, with 80 new members at UK and 82 from UL. These efforts resulted in monetary awards to the chapters from the AMA to fund student delegates to the AMA-MSS meetings. An AMA Chapter Award went to Amy Waltrip, President of the UL KMA-MSS, for recruiting the highest number of students for four-year memberships in UL's freshman class size category — 79% of the first-year class.

We are grateful for the opportunity to be involved on several of the committees of the Association and to be asked to serve on the House of Delegates reference committees. The section would like to thank the officers, delegates, and all KMA members for their support of medical student activities and the opportunity given to us to have a voice in the affairs of organized medicine.

Michael Todd Newman, UK President
Amy Waltrip, UL President

Report of the KMA Membership Task Force

The KMA Membership Task Force was appointed by the Board of Trustees in April 1997 on the recommendation of a previously appointed Task Force on Female Physicians which asked that its role be expanded to focus on all levels and segments of the physician population in membership issues. Based on that recommendation, the KMA Alternate Trustees and C. Kenneth Peters, MD, KMA President-Elect, were asked to serve with the original task force members. The task force is now composed of a broad representation of the membership population; eg. women, rural practice, young physicians, academic, international medical graduates, employed physicians, residents, and medical students.

The first meeting of the Membership Task Force, held June 6, 1997, was a brainstorming session to share concerns, issues, and problems relating to membership in KMA. A number of problem areas that keep physicians from joining were identified by the task force:

- There seems to be a negative/pessimistic attitude about organized medicine, credited in part to physician apathy and the image of organized medicine. There needs to be a diminishing defensive approach to problems, while the Association becomes more proactive, increasing its involvement in patient advocacy issues.

- The perceived value received for dues dollars is always a concern. There is an increasing competition for physicians' time and money from many different areas including specialty societies and CME needs.
- The Association does not provide many benefits exclusive to members. All physicians, whether members or not, share in the benefits at the expense of those that participate financially and otherwise.
- Current communication methods restrict participation and involvement in Association activities by physicians across the state. A feeling of isolation by rural physicians and a lack of networking capabilities are obstacles to membership that can be overcome with technological advances.

Following an in-depth discussion of these problems and suggestions for addressing them, the task force summarized the major issues discussed into specific goals, with an overall purpose statement as follows:

The overall objective of the Membership Task Force is to (1) strengthen membership through recruitment of new members and retention of existing members and (2) encourage an increased level of participation in Association activities; thereby establishing a stronger, more cohesive community of physicians working together for the common purposes of the Association. To achieve these goals, four major areas of concentration have been identified by the task force as crucial to membership development.

I. COMMUNICATIONS

KMA needs to move forward in technological communications with members, with committees, and with leadership. Areas that need to be explored for possible implementation include: teleconferencing, videoconferencing, E-mail communications, and a Web site.

II. ADVOCACY/VISION

KMA needs to find out what physicians (members/nonmembers) want and need and develop a proactive vision statement for where the association needs to be. Areas that need to be explored for possible implementation include: focus groups in every trustee district and member target group (eg. residents, faculty, large groups); exit survey follow-up for nonrenewals; and peer-to-peer contacts.

III. PRACTICAL BENEFITS

As a result of market research, KMA needs to identify and develop specific benefits/services that are exclusive to members.

IV. LINKAGES

KMA needs to establish a community of physicians through local, personalized involvement, creating an environment in which physicians will have pride in belonging. Areas that need to be explored for possible implementation include: physician mentoring program, availability of KMA leadership/staff at county society meetings, and enhanced communications through technology to link rural MDs with entire state.

The Membership Task Force will be pursuing the feasibility and value of these specific areas in the next few months and will be reporting to the Board its recommendations in order to secure and assure the future of membership in this Association. We thank the Board for its confidence and freedom to explore avenues that may have far-reaching implications for the future direction of KMA and welcome input from members of the House of Delegates in this undertaking.

Ardis D. Hoven, MD
Chair

Report of the Ad Hoc Committee on Faculty Membership

The Ad Hoc Committee on Faculty Membership was appointed to identify and develop policy on issues of concern to academic physicians, and to help enhance membership in this segment of our profession.

The Ad Hoc Committee was appointed in February and has had three meetings with another scheduled in the next few weeks. The members of the committee are: Susan Galandiuk, MD, Louisville; Frank B. Miller, MD, Louisville; Barbara Phillips, MD, Lexington; and Daniel E. Kenady, MD, Lexington. Because many membership activities have traditionally taken place quite effectively at the county society level, the committee has asked the chief executives of the Fayette and Jefferson County Medical Societies, Mrs Carolyn Kurz and Mr Lelan Woodmansee, to meet with the group in an ex-officio capacity, as well as Mrs Diane Maxey, membership director on the KMA staff.

The most immediate and obvious need was an understanding of the

acceptance and value of professional association services to faculty physicians. To this end, a survey was developed to submit to each faculty physician. The original intent of the survey was to serve as a tool not only to help familiarize faculty physicians with the services of KMA and the county society, but also to solicit their views about activities that their professional organizations should be involved in to serve their needs.

This survey was based on information derived from committee members' views, from similar efforts conducted in various places around the country, and from work already in progress by the Jefferson County Medical Society. The survey document underwent three drafts and then was further refined through focus groups. Members of the committee selected peers to test the survey for appropriateness, clarity, and the time required to complete the instrument.

Notices of the survey were published in the Jefferson and Fayette County monthly newsletters and the KMA *Communicator*. The survey was submitted to each faculty physician in both schools. It was sent with a cover letter from the respective dean, respective county society president, and the KMA president. A deadline for completion was given and return response was requested by mail or fax. Following the termination date, a response rate of approximately 20% was realized from both schools.

A rough analysis of the survey has been completed and committee members are now taking a closer look at the results.

Along with this work, the Ad Hoc Committee on Faculty Membership is also undertaking the development of a brochure focused towards university physicians in each facility that highlights member benefits for their specific professional situation. Early on we learned, and a tentative analysis of the survey responses confirms, that there are commonalities among all faculty physicians, but some dynamics unique to each specific school locale. Each school has different traditions, community/academic relationships, and medical practice environments. It is the committee's intent to tailor different versions of the brochure specifically for each area. Additionally, the two involved county societies have unique activities which will be highlighted in separate brochures as they were in the survey documents.

The committee plans to meet again in the next few weeks to try to identify some directions that are appropriate for KMA to take to suit faculty physicians' needs. The committee will then try to recommend efforts to meet those needs or resolve other issues that are identified. Following this review, the committee plans to further develop recommendations about what role it might play, as well as other appropriate efforts to take that could involve other KMA committees or Board activities.

Together with this material and the brochure being developed, the committee's self-imposed deadline was developed to be able to promote membership in the next solicitation cycle.

All of the committee members, though extremely busy, have given energetically of their insight and assistance. The group has been enthusiastic and productive, and we anticipate some positive results.

Preston P. Nunnolley, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Pro Advisory Committee

In recent years the Professional Review Organization (PRO) has moved to projects to improve care and respond to Medicare beneficiary complaints and away from specific case review and sanctioning for instances of poor care.

The new education-oriented approach to changing medical care has made attempts to analyze medical practice patterns, identify opportunities for improvement, and implement changes that prove effective. What has been found to be ineffective in a case review has been completely eliminated.

To improve the mainstream of care in the Medicare program, PROs around the country have been urged to develop so-called quality improvement initiatives through the Health Care Quality Improvement Program (HCQIP). Nationally, two clinical data abstraction centers gather information which is abstracted from 200,400 medical claims reviewed annually. This data is then used to analyze national trends as well as local variations from national averages, and outcome measures are derived.

By encouraging and monitoring a large number of PRO projects, the Health Care Financing Administration (HCFA) is able to assess how to implement successful projects regionally and nationally, as locally developed projects effectively serve as "pilot tests." So far, PROs around the country have

completed 244 such projects.

One such project participated in by the PRO for Kentucky has been the Cooperative Cardiovascular Project (CCP). Begun in January 1995, the purpose of the CCP is to study the care and outcomes for 224,377 Medicare hospital discharges with the primary diagnosis of acute myocardial infarction (MI). Ten clinical indicators of care for MI that had been developed jointly by the American College of Cardiology and American Heart Association were abstracted from charts. This data is undergoing a final analysis phase, but preliminary considerations indicate an overall improvement in MI care nationwide through the use of these indicators. This is a clear and positive example of the type of PRO project designed to improve care.

The second major area of focus has been responding to Medicare beneficiary complaints. Through the Office of the Inspector General of the US Department of Health and Human Services, HCFA began a project to identify perceived flaws in the Medicare beneficiary complaint process and to work to identify ways to respond to complaints more quickly and efficiently. Through regulatory efforts, separate development of PRO program rules, and pilot projects, this program has seen considerable effort for change.

Nationally, the American Medical Association (AMA) has expressed some concern over these efforts. The primary concern surrounds the issue of physician consent to disclosure of review findings. Previous confidentiality proscriptions prevented HCFA from revealing these refuted findings that resulted from beneficiary complaints until the physician involved had access to full due process, and this remains a point of ongoing argument.

In a similar vein, the AMA has objected to PRO review of physician office activities. Although such review is within the scope of the statute covering review of Medicare services, there is concern that HCFA has never offered guidelines as to how such a review should be conducted. The AMA has urged that the physician office review be pilot-tested to insure PRO proficiency, and in some pilot areas PROs have concurred that this lack of guidelines diminishes the objectivity of review. While all physicians support appropriate efforts to improve the means by which patients can express and obtain information about concerns with quality of care that they have received, the PRO program must ensure confidentiality of review and due process for physicians if physicians are to continue to cooperate with PRO program.

One of the primary responsibilities for which the PRO Advisory Committee was initially established was to serve as an advocate on behalf of the physicians. Because the PRO Program has evolved to a more decentralized data analysis management activity, there is less direct observable association with day-to-day physician practice. This has negated the committee's role as advocate. Similarly, educational efforts on the part of the PRO have primarily taken place at local practice sites, and this has diminished any educational and communications role the committee could fulfill.

For these reasons, it is recommended that the PRO Advisory Committee be disbanded and general monitoring of PRO efforts be left to the Board of Trustees until such time as more intense monitoring is indicated.

William H. Mitchell, MD
Chair

RECOMMENDATIONS:

1. It is recommended that the PRO Advisory Committee be disbanded and general monitoring of PRO efforts be left to the Board of Trustees until such time as more intense monitoring is indicated.

Recommendations, Reference Committee D:

Reference Committee D considered the Report of the PRO Advisory Committee and its Recommendation that the PRO Advisory Committee be disbanded, and general monitoring of PRO efforts be left to the Board of Trustees until such time as more intense monitoring is indicated. Reference Committee D recommends that the Report of the PRO Advisory Committee and its Recommendation be adopted.

Report of the Committee to Investigate Changing Trends in Medicine

There is a widely held belief throughout the United States that money lost through fraud and abuse in the health care system constitutes a significant amount of the money spent, especially in Medicare. This belief has led to a wide array of legislation throughout the country in an effort to crack down on alleged fraud and abuse. The system that has been created to conduct



these investigations, however, is a self-perpetuating system. The government is able to use the money it receives through settling these cases to further investigate fraud and abuse in the health care system. Recent estimates have speculated that for every dollar spent on investigating health care fraud and abuse, the federal government receives 23 dollars in settlements. Among hospitals it has been estimated that 4,700 of the nation's 6,300 hospitals are responding to investigations and the American Hospital Association has gone so far as to ask for a six-month moratorium on all investigations.

The Committee to Investigate Changing Trends in Medicine met once over the past year to discuss fraud and abuse laws and their effect on physicians. The committee received information and presentations on these laws from Martha Hasselbacher, an attorney with the law firm of Stites & Harbison in Louisville, and Patrick Padgett, Director of Socioeconomic Affairs and Staff Counsel for the KMA. Their presentations elicited a tremendous amount of discussion among the committee members, who all expressed deep concern about the current climate regarding fraud and abuse. The committee's foremost concern was the education of physicians on the various laws and regulations with which they must comply in an effort to avoid investigations by law enforcement officials. There is no doubt that the taint of an investigation can be as damaging to a physician's practice as an indictment or conviction for criminal wrongdoing.

Law enforcement officials are currently conducting a large number of investigations and their methods raise enormous concerns for physicians. When investigators show up at a physician's office to begin an investigation, many times original medical records are taken as evidence and are not returned for many months. There have also been scenarios where yellow crime scene tape is put around a physician's office and patients are told to leave and go see a "real doctor."

The federal government currently has a wide array of laws to use against physicians. The federal Anti-kickback Law prohibits physicians from receiving anything of value in exchange for a referral to another organization. The value received could be as simple as a pizza being delivered to a physician's office by a local hospital. This law, therefore, is very broad and physicians should be aware that anything they receive from another health care entity could be interpreted as a "kickback."

Congress has also passed what has been commonly known as the "Stark laws." These laws create express prohibitions between certain physician-provider relationships without regard to whether the parties intend to induce referrals. The existence of a financial relationship between a physician and another provider can be triggered if the relationship involves ownership, investment, debt, or compensation arrangements between the parties. Services covered under this law include: clinical laboratory services, physician therapy services, occupational therapy services, radiology services, radiation therapy services, durable medical equipment, home health services, outpatient prescription drugs, and inpatient/outpatient hospital services. The prohibition against any type of investment also extends to a physician's family.

The federal government is using other statutes to prosecute physicians. Some physicians have been prosecuted under the federal mail and wire fraud statutes for waiving co-payments. They have also been investigated for providing services that the federal government believes are not necessary. This is especially troubling because the government, by taking such action, is second guessing physicians in their direct treatment of patients. One reason that Medicare claims are frequently prosecuted under mail fraud is that the statute allows for the seizure of the physician's assets.

Many providers are also being prosecuted under the Racketeer Influenced and Corrupt Organization's Act, also known as "RICO," which prohibits anyone from receiving income from actions that constitute a pattern of "racketeering activity." This statute is most commonly used against organized crime, which shows the level federal investigators are willing to go to obtain convictions against health care providers. In essence, we are being treated as "Mafia henchmen."

There have been many cases against physicians involving the Federal False Claims Act, which was passed during the Civil War to prevent manufacturers of military equipment from producing and providing shoddy products to the government. In essence, a prosecution under this law is based on someone claiming money from the government and using false statements in order to obtain that money. This law is being used by law enforcement against physicians because of the potential for false claims being submitted by physician offices in the Medicaid/Medicare systems. Physicians should be

careful to educate themselves and their office workers on proper procedures for filing claims because they can be held liable for violations of the law.

The False Claims Act also allows for "qui tam" actions, which allow a citizen to sue a health care entity on behalf of the government. The Department of Justice receives these suits under seal and decides whether to participate in the suit. Many citizens are filing these suits because they can get anywhere from 10% to 25% of a civil money settlement. These types of actions open up the prospect of physicians being sued by competitors or disgruntled employees.

Last year, in an effort to expand health care fraud and abuse laws, Congress passed the Health Insurance Portability and Accountability Act, commonly referred to as "HIPAA" or "Kennedy/Kassebaum." This law expanded many current health care fraud laws to apply to not only the Medicaid and Medicare systems, but also to *any* health benefit plan, including private insurance plans. In other words, physicians may now be prosecuted for committing fraud against a private insurance carrier.

HIPAA created, on top of existing fraud laws, new health care crimes that can be used by federal investigators and prosecutors. These new crimes include: health care fraud, embezzlement, providing false statements, obstruction of criminal investigations of health care offenses, and money laundering by health care providers.

HIPAA also established incentives for patients and employees to report physicians for violations of federal law. Whoever reports such a violation receives a portion of the amount collected from any prosecution or civil action. Physicians should be concerned about this new aspect of the law because it will change the relationship between physicians, their patients and employees.

HIPAA mandated exclusion from Medicare and Medicaid for those who violate any health care related crime. This mandatory exclusion from Medicare/Medicaid can also be imposed on a physician for failure to comply with statutory obligations regarding quality of care, which again means the federal government will be intruding on the decision-making process of a physician.

HIPAA also created exclusions from Medicare and Medicaid for the direct or indirect ownership or control of a "sanctioned entity." This means physicians could be excluded from Medicaid or Medicare for having an ownership interest in an entity that has been sanctioned for violating health care laws, whether or not the physician had direct involvement in the violation. These exclusions can also extend to officers or managing individuals, which include medical directors of entities such as nursing facilities and health maintenance organizations. The committee was especially concerned about this aspect of the new law because medical directors may be excluded in their own practice from Medicare/Medicaid by serving as the medical director of a completely separate entity.

In an effort to track physicians, HIPAA created a National Health Care Fraud and Abuse Data Collections Program to report final adverse actions against physicians. An "adverse action" is broadly defined in the statute and may allow for the reporting of settlements against physicians. This puts physicians in a very difficult situation. The government is currently using the threat of exclusion from Medicaid and Medicare in order to get physicians to settle cases, while at the same time such a settlement may be reported to the National Data Collection Program.

Statistics regarding health care investigations are eye opening. The FBI Fraud Unit conducted 365 such investigations in 1991, while in 1996, prior to the enactment of HIPAA, 2,000 investigations were conducted by the unit. Since the enactment of HIPAA, the Department for Health and Human Services Office of the Inspector General has closed nearly \$1 billion in settlements. Two investigations of teaching hospitals earlier in the year netted the government nearly \$42 million in settlements.

While there are many investigations being conducted under current law, there has been an effort to pass even broader health care fraud and abuse laws. President Clinton proposed such a law earlier in the year. While the President's bill was defeated, there is another bill currently before Congress that would fine any provider who "knew or should have known" that they were contracting with another health care provider who had been excluded from the Medicare and Medicaid systems. Such a bill is alarming because it is hard to find out if a certain entity has been excluded from those programs.

The amount of money collected from fraud cases will lead to more investigations by the government. The trend seems to be for the government

to prosecute under the False Claims Act because it has not had much success prosecuting the anti-kickback cases. There is a move afoot to penalize providers for cutting back on the amount of care given to a patient in order to receive a financial incentive, as well as a trend to allow private lawsuits by citizens against managed care entities for not providing enough care. There is also the danger that the current information database that reports settlements may be used as a tool to target certain providers for additional investigation.

The war on drugs seems to be dead and the new target by the government appears to be health care. Such entities as the National Health Care Anti-Fraud Association and the National Council Against Health Fraud have been formed in response to this new national priority. Physicians should be familiar with the laws in this area and educate their office staff on the proper procedures to avoid any problems, but should seek the advice of an attorney if potential issues come up in their practices. Physicians should also consider hiring someone to review the procedures in their practices to determine whether they are in compliance with fraud and abuse laws.

When a review of office procedures is considered, physicians should also look into the need for "corporate compliance plans." These plans are formulated by consultants and attorneys for use by various health care entities to assist in complying with the various laws and regulations. In many cases, if the provider can prove to the government that he did everything possible to comply with the law, including implementing a corporate compliance plan, the fines for violations can be lower. Of course, such plans will create more paperwork for physicians and their practices, not to mention the cost of implementing such a plan.

All is not gloom and doom. Among academic circles, there seems to be a movement to restrict the use of fraud and abuse laws because they pose barriers to providers integrating and holding down the costs of medical care in the private sector. There also seems to be concern that more attention is being focused on finding those who have already committed violations as opposed to implementing procedures to prevent violations. This trend, hopefully, will lead to a rational evaluation of fraud and abuse laws to determine their effect on the ability of physicians to provide adequate care to their patients at the lowest possible cost.

Marjorie R. Fitzgerald, MD
Chair

RECOMMENDATIONS:

1. That the final report of the committee, along with other articles describing some of the various laws with which physicians should be concerned, appear in the *Journal of the Kentucky Medical Association*.
2. That KMA disseminate educational materials around the state, sponsored by KMA and other societies, to educate physicians and office managers on the pitfalls of some of the fraud and abuse laws; and
3. That KMA schedule a seminar on fraud and abuse during the 1998 Annual Meeting.

Recommendations, Reference Committee D:

Reference Committee D next considered the Report of the Committee to Investigate Changing Trends in Medicine and its three Recommendations concerning fraud and abuse laws. Reference Committee D recommends that the Report of the Committee to Investigate Changing Trends in Medicine and its three Recommendations be adopted.

RESOLUTION 97-106

Dues-Free Membership for Resident Physicians Jefferson County Medical Society

WHEREAS, resident physicians comprise the future active membership of the Federation of American Medicine; and

WHEREAS, the period of residency training affords an outstanding opportunity for young physicians to join their medical associations and to become familiar with the benefits of participation; and

WHEREAS, experience indicates that physicians are much more likely to join and maintain their membership if they join during their residency training; and

WHEREAS, with the current nominal annual dues structure, about one-third of resident physicians who join KMA and the Jefferson County Medical Society in their first program year fail to renew in their subsequent years; and

WHEREAS, a one-time membership decision to continue for the duration of residency training would eliminate this attrition, to the benefit of both the physician and the Association; now, therefore, be it

RESOLVED, that Kentucky Medical Association policies or Bylaws, as appropriate, be amended to permit the KMA and county medical societies in which residency programs are located to offer, by mutual agreement, membership to resident physicians (PGY 1-5) for the duration of their residency training period for a one-time processing fee with no annual dues.

Recommendations, Reference Committee D:

Reference Committee D reviewed Resolution 97-106, Dues-Free Membership for Resident Physicians, submitted by the Jefferson County Medical Society. Much discussion was recounted from the Rural Caucus meeting. There was Reference Committee discussion regarding the issue that In-Training members are not counted toward delegate designation from local county medical societies. There was also discussion about administration of the fee.

Reference Committee D recommends a substitute for Resolution 97-106, to read as follows:

RESOLVED, that the KMA and county medical societies in which residency programs are located offer, by mutual agreement, membership to resident physicians (PGY 1-5) for the duration of their residency training period for a one-time fee; and be it further

RESOLVED, that Chapter IX, Section 1 (4), of the KMA Bylaws be amended to read "(4) In Training Members: a one-time fee shall be established by the Board of Trustees."

Harry W. Carlross, MD, Paducah, proposed the Board of Trustees amendment, as follows:

RESOLVED, that the KMA and county medical societies in which residency programs are located offer, by mutual agreement, membership to resident in-training physicians (PGY 1-5) for the duration of their residency training period for a one-time fee; and be it further

RESOLVED, that Chapter IX, Section 1 (4), of the KMA Bylaws be amended to read "(4) In Training Members: a one-time fee dues shall be established by the Board of Trustees."

The Board amendment to the substitute resolution was adopted. The substitute resolution for 97-106 was adopted as amended.

RESOLUTION 97-107

Shifting of Administrative Burdens by Insurance Companies Jefferson County Medical Society

WHEREAS, it appears there may be a trend among medical insurance companies to decrease physician reimbursement for medical services but, at the same time, to shift an increasing load of uncompensated administrative responsibilities to the physician; now, therefore, be it

RESOLVED, that the Kentucky Medical Association direct its Committee on Medical Insurance and Prepayment Plans, or another appropriate body, to monitor and address the problem of insurance companies shifting administrative responsibilities to physicians without adequate compensation; and be it further

RESOLVED, that KMA inform the membership of the committee's involvement and encourage members to submit pertinent information and to have input into the committee.

Recommendations, Reference Committee D:

Reference Committee D considered Resolution 97-107, Shifting of Administrative Burdens by Insurance Companies, submitted by the Jefferson County Medical Society. Testimony was heard and discussion was held in great depth regarding this resolution. Reference Committee D recommends a substitute for Resolution 97-107, to read as follows:

RESOLVED, that the Kentucky Medical Association monitor and make recommendations on the problem of insurance companies shifting administrative responsibilities to physicians without adequate compensation; and be it further

RESOLVED, that KMA members are encouraged to submit to the KMA Board of Trustees pertinent information on the shifting of insurance companies' administrative responsibilities and costs to physicians.



RESOLUTION 97-115

Medical Practice Business Expenses Jefferson County Medical Society

WHEREAS, physicians' offices must function as business entities; and
WHEREAS, business expenses rise from year to year; and
WHEREAS, insurance companies recently have been decreasing reimbursement for patient care; now, therefore, be it

RESOLVED, that the Kentucky Medical Association urge insurance companies to make accommodations yearly in their physician reimbursement schedules for the ever-increasing business expenses of maintaining medical practices.

Recommendations, Reference Committee D:

Reference Committee D considered Resolution 97-115, Medical Practice Business Expenses, submitted by the Jefferson County Medical Society. Following discussion of this matter, Reference Committee D recommends a substitute for Resolution 97-115, to read as follows:

RESOLVED, that KMA urge third-party payers to make appropriate accommodations in their physician reimbursement schedules for business expenses resulting from requirements the payers impose.

Susan Bornstein, MD, Louisville, noted that this resolution was intended to relate to business practice expenses, which the substitute did not address. The intent was to ask for a "cost of living" adjustment for routine business expenses, not those imposed by third-party payers, and she asked that the original resolution be adopted.

The reference committee substitute for Resolution 97-115 was rejected, and the original version of Resolution 97-115 was adopted.

RESOLUTION 97-118

Alternative Medical Practice Kentucky Academy of Family Physicians

WHEREAS, the term "alternative medicine" has become a household word in America; and

WHEREAS, "alternative medicine" is viewed with increasing interest and even hope by both patients and physicians; and

WHEREAS, medical students and physicians are asking information about promising alternative therapies; and

WHEREAS, an increasing number of unlicensed and non-certified practitioners are offering alternative therapies in Kentucky; and

WHEREAS, some physicians interested in offering alternative therapies to patients are confused about proper procedure due to the lack of clear guidelines in Kentucky; and

WHEREAS, alternative practitioners lobbied in the last Kentucky legislature for new regulations permitting easier practice in Kentucky; and

WHEREAS, the Kentucky medical community and their patients stand to gain from a rational, informed integration of alternative therapies into mainstream medicine; and

WHEREAS, the Kentucky Medical Association is the state's premier organized medical organization; now, therefore, be it

RESOLVED, that KMA establish a Committee on Alternative Medicine to proactively work on formal guidelines for the practice of alternative therapies in Kentucky.

Recommendations, Reference Committee D:

Reference Committee D next considered Resolution 97-118, Alternative Medical Practice, submitted by the Kentucky Academy of Family Physicians. Testimony was heard on this resolution, and there was a great amount of support from the attendees at the reference committee hearing that a committee should be established, rather than essentially referring the matter back to the Board for further study. The attendees were also in agreement that the name of the committee also include the word "unconventional." Additionally, the reference committee felt that this new committee should probably "sunset."

Reference Committee D recommends, therefore, that the Resolved section of Resolution 97-118 be amended to read as follows:

RESOLVED, that KMA establish an Ad Hoc Committee on Alternative and Unconventional Medicine to proactively work on formal guidelines for the practice of alternative therapies in Kentucky.

Mr Speaker, Reference Committee D recommends the adoption of Resolution 97-118 as amended.

After much discussion on the floor of the House, Greg Cooper, MD, Cynthiana, recommended referral to the Board of Trustees. Resolution 97-118 was referred to the Board.

RESOLUTION 97-123

Parity for Mental Illness in Medical Benefits Programs Kentucky Psychiatric Association

WHEREAS, mental illnesses are diagnosable, treatable, and curable; and

WHEREAS, all health insurance plans should be responsive to the principle of providing benefits for mental illness, alcoholism, and substance abuse at parity with other illnesses; now, therefore, be it

RESOLVED, that our KMA support parity of coverage for mental illness, alcoholism, and substance abuse.

Recommendations, Reference Committee D:

Reference Committee D considered Resolution 97-123, Parity for Mental Illness in Medical Benefits Programs, submitted by the Kentucky Psychiatric Association. Testimony was heard and discussion was held, and it was clarified that mental illness includes alcoholism and substance abuse.

Reference Committee D recommends a substitute for Resolution 97-123, to read as follows:

RESOLVED, that KMA supports the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other illnesses.

RESOLUTION 97-129

Reaffirmation of Resolution R (1995) Fayette County Medical Society

WHEREAS, the Kentucky General Assembly will meet in 1998; and

WHEREAS, optometrists as primary care providers is a topic of continuing interest; now, therefore, be it

RESOLVED, that the Kentucky Medical Association reaffirm Resolution R from its 1995 House of Delegates, to wit: "RESOLVED, that the Kentucky Medical Association opposes legislation allowing optometrists to act or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery in the Commonwealth of Kentucky."

Recommendations, Reference Committee D:

Reference Committee D considered Resolution 97-129, Reaffirmation of Resolution R (1995), submitted by the Fayette County Medical Society. Reference Committee D recommends that Resolution 97-129 be adopted.

RESOLUTION 97-134

Mandatory Provisions in Health Insurance Policies Board of Trustees

WHEREAS, medical insurance philosophy, structure, and operations have undergone a quantum change since contractual health coverage first became prevalent; and

WHEREAS, the reaction of physicians and this Association to these changes has evolved apace with a constant focus to preserve the quality of care and to protect patient welfare; and

WHEREAS, the earlier insurance climate which was dominated by nonprofit, patient-oriented insurance caused this Association to oppose mandatory coverage of specific benefits; and

WHEREAS, the current insurance philosophy of profit-oriented managed care has resulted in practices that have provoked negative public, legislative, and physician reaction; and

WHEREAS, these practices — such as mandated length of stay limits, mandatory outpatient service delivery sites, and the absence of coverage for specific services determined by cost — have prompted legal or statutory coverage of specific items; now, therefore, be it

RESOLVED, that KMA supports payment for medically necessary services by insurers/payers based on the appropriate care of the patient; and be it further

RESOLVED, that decisions regarding insurance coverage of medical services be considered separately for each service in question in the context of patient need and the physician's medical judgement.

Recommendations, Reference Committee D:

Reference Committee D considered Resolution 97-134, Mandatory Provisions in Health Insurance Policies, submitted by the Board of Trustees. Reference Committee D recommends that Resolution 97-134 be adopted.

Mr Speaker, Reference Committee D recommends the adoption of the Report of Reference Committee D as a whole, as amended.

Mr Speaker, I want to personally thank the other members of Reference Committee D who have attempted to assist the House of Delegates in formulating policies on some very worthwhile issues. Members of the Committee were: Elizabeth A. Farmer, MD, Louisville; Jerome L. Krumpelman, Jr, MD, Richmond; Judy M. Linger, MD, Georgetown; Deborah B. Mattingly, MD, Bardstown; and John D. Stewart, II, MD, Lexington. I would also like to thank Debby Traugher for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE D
K. Thomas Reichard, MD, Chair
Elizabeth A. Farmer, MD, Louisville (RPS)
Jerome L. Krumpelman, Jr, MD, Richmond
Judy M. Linger, MD, Georgetown
Deborah B. Mattingly, MD, Bardstown
John D. Stewart, II, MD, Lexington

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE E

John A. Patterson, MD, Irvine, Chair

34. Report of the Committee on Maternal and Neonatal Health
35. Report of the Technical Advisory Committee on Physician Services (Medicaid)
36. Report of the Committee on Community and Rural Health
37. Report of the Committee on Physical Education and Medical Aspects of Sports
38. Report of the Committee on Child and School Health
39. Report of the Judicial Council
40. Report of the Interspecialty Council
- Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan
- Resolution 101 — Reduction of Tobacco Use While Assuring Community Economic Stability
(Estill County Medical Society)
- Resolution 102 — Community Authority for Reduction of Tobacco Use by Children
(Estill County Medical Society)
- Resolution 111 — Smoking in Children
(Fayette County Medical Society)
- Resolution 125 — Commercial Poultry and Swine Industry
(Estill County Medical Society)
- Resolution 130 — Phen-Fen Prescriptions
(Fayette County Medical Society)
- Resolution 135 — Sale of Tobacco
(Board of Trustees)
- Resolution 136 — Tobacco Settlement
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee E reviewed the following items and recommends they be filed, by consent of the House, without discussion:

35. Report of the Technical Advisory Committee on Physician Services (Medicaid) — filed
37. Report of the Committee on Physical Education and Medical Aspects of Sports — filed
38. Report of the Committee on Child and School Health — filed
39. Report of the Judicial Council — filed

40. Report of the Interspecialty Council — filed

Reference Committee E would like to express its appreciation to the chairs and members of these committees for their efforts in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee E recommends adoption of the Consent Calendar as a whole.

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The Technical Advisory Committee on Physician Services (Title XIX), (TAC) is one of the 11 provider groups represented on the Advisory Council for Medical Assistance, which advises the Secretary for Health Services on Medicaid issues. The TAC meets as needed to discuss and evaluate problems and concerns faced by physicians when dealing with the Medicaid program. If the TAC determines that the issues discussed require action, they are presented in a report to the Advisory Council for action. The TAC meetings are subject to the provisions of KRS 61.805-61.850, the Kentucky Open Meetings Law, which requires all TAC meetings to be open to the public and scheduled to allow effective public observation and media coverage.

The TAC had a very busy year. The committee met three times to hear reports on a number of issues concerning Medicaid. Throughout the year, the Committee heard from the Department for Health Services regarding the Medicaid Managed Care Program being implemented throughout the state. The state has been divided into eight regions for the purposes of the Medicaid program and each region has the opportunity to form a "partnership" to manage the Medicaid program in that region. If a region does not form a partnership, the department will take bids from other private HMOs to service the Medicaid program in that region. The department would like all partnerships to be established in the next two to four years.

The partnerships in regions three and five, which encompass Louisville and Lexington respectively, will most likely be established first. The TAC heard presentations from each of those regions regarding the administrative, legal, business, and provider components; proposed payment structures; and progress in meeting the requirements of the Medicaid waiver. At the first TAC meeting, the region three representative said it would be operational by July 1, 1997. The region five representative said it should be operational by August 1, 1997. Since that meeting, however, the establishment of these partnerships has been moved back to September or October of 1997.

Members of the TAC expressed concern about the establishment of the partnerships and their effect on providers and patients within the Medicaid program. The committee questioned why the KenPAC Program could not be improved to meet the needs of Medicaid providers and recipients, while at the same time saving money for the state. It was noted that the KenPAC system has been nationally recognized, although improvements could be made.

The TAC also received reports from the Department of Medicaid Services on the \$52 million settlement between the KMA and the department. Notification to physicians regarding payment of the settlement was sent in November 1996 and this included a list of claims paid through October 31, 1996, for services provided from July 1, 1995, through June 30, 1996. Physicians had 30 days from their date of notification to request corrections to their paid claims listing, with disputed payment totals being resolved by January 31, 1997. The checks were mailed to physicians in late January 1997. A few physicians did receive changes in the amount of money claimed; however, most appeals were rejected for one reason or another.

The TAC also received reports regarding CPT coding. KMA House of Delegates' Resolution 96-117 regarding AMA CPT coding was forwarded to the TAC for action. The Department for Medicaid Services reported that it does accept the AMA CPT coding and has a peer review organization providing physician services and expertise to the department regarding the development of criteria by which the department can implement modifiers which will be compatible with the AMA's. The department noted that it is using its PRO as a liaison with the AMA and said that as soon as the department receives a response from the PRO, the information would be shared with the TAC.

The TAC also took up the issue of Advance Registered Nurse Practitioners (ARNP) being given the status of primary care providers in the KenPAC system. The Department for Health Services asked for the TAC's opinion as to whether ARNPs should be KenPAC providers. The department said there are



not enough KenPAC providers throughout the state, and ARNPs can fill the void in counties where there are not any physicians to treat KenPAC patients. The TAC expressed concern regarding the ARNPs ability to establish an independent practice, and felt ARNPs should make no decision concerning patient care that they are not qualified to make. The issue was later taken to the Advisory Council by the Nurses' Technical Advisory Committee.

The Department for Health Services requested the TAC's opinion as to the reimbursement rate for nurse midwives. The Secretary for Health Services was petitioned by Patty A. Clay Hospital in Richmond regarding whether nurse midwives should receive 100% of the obstetrical payment rate for deliveries. Nurse midwives currently receive 75% of this rate. The TAC did not support the nurse midwives' request because it was felt nurse midwives do not offer the same services and quality of care given by physicians. The TAC also expressed concern about the amount of education given to nurse midwives, as well as the ability to provide necessary care in the event of unforeseen problems during delivery. The TAC's concerns regarding this issue were expressed to the Advisory Council.

The Kentucky Academy of Physician Assistants presented to the TAC a recommendation that physician assistants' work be reimbursed to physicians in the KenPAC Program. It was noted that Kentucky law allows physician assistants to perform any and all medical services within the scope of training received by an approved program and within the scope of the supervising physician's practice. The Department for Medicaid Services currently does not allow physicians to be reimbursed for the work done by physician assistants because they are "certified" and not "licensed." Twenty states throughout the country use the term "certification" to define a physician assistant's ability to practice. Eighteen of those states allow reimbursement for physician assistants treating Medicaid patients. While federal Medicaid law does not mandate the inclusion of physician assistants, federal Medicaid officials encourage the utilization of appropriately trained providers such as physician assistants to help increase access to Medicaid patients. The TAC reported the idea of physicians being reimbursed for physician assistant services, and this position was communicated to the Advisory Council.

The TAC also took up the issue of proper utilization of home health, rehabilitation, and ancillary services. KMA Resolution 96-123 was forwarded to the TAC and stated the following: "Resolved, that the KMA develop or adopt in consultation with physicians and other appropriate organizations, guidelines for the prescribing and utilization of nursing home services, home health services, and rehabilitation services." In an effort to work with the Department for Medicaid Services on this issue, a meeting was held between the Physician TAC, Nursing Facility TAC, various representatives of other TACs, various representatives of the Medicaid staff, and representatives of the Medicaid PRO. The meeting was very productive and gave all sides a chance to express their concerns regarding the procedures for ordering therapy services in nursing facilities. There were many misunderstandings regarding the amount of services ordered and the procedures for ordering these services. The members of the Physician TAC obtained copies of guidelines that have already been written by the Medicaid PRO regarding the ordering of therapy services in nursing facilities. It was the impression of the Physician TAC that all physicians should be educated on these guidelines in an effort to help reduce unnecessary services ordered in nursing facilities. It was also suggested by members of the Physician TAC that physicians should closely scrutinize orders written by therapists in nursing facilities and even suggested that physicians write the orders themselves to avoid any misunderstandings. The Nursing Facility TAC was told by the Medicaid PRO that many therapists see patients in nursing facilities without the order of a physician. Physicians expressed concern about this procedure and members of the Nursing Facilities TAC said they were unaware of the problem and would address it.

The Physicians' TAC has had a very busy year and continues its efforts to provide a meaningful forum for Kentucky's physicians to present their concerns and ideas in providing quality medical services to Kentucky's indigent population. As chair, I would like to express my appreciation to my fellow committee members for their time and efforts during this very busy year. I would also like to thank the members of the Department for Medicaid Services staff, Secretary John Morse, and the representatives from the other TACs who have provided information to us throughout the year.

Salem M. George, MD
Chair

Report of the Committee on Physical Education and Medical Aspects of Sports

The Committee on Physical Education and Medical Aspects of Sports met on two occasions during the 1996-97 Association year to monitor the physical health, safety, and well-being of children involved in athletics at the high school level and below. All members of the committee are committed to working with schools, coaches, and athletic trainers in their areas to promote the safety of students.

The committee continues to oversee the development and sponsorship of sports medicine symposia around the state. As a result of the committee's close ties with Julian Tackett and the Kentucky High School Athletic Association (KHSAA), it is required that all high school coaches and athletic trainers receive certification through one of the symposia every two years. This year, the committee sponsored 15 symposia across the state, and final attendance figures are still being compiled.

The statutory recognition of athletic trainers and the certification requirements have unquestionably resulted in improved monitoring and care of school athletes, and have had a substantial effect on training methods. As newly developed methods in treating ailments, accidents, and injuries are discovered, the committee is able to have a direct effect on training and competition to meet these advances. Our symposia provide updates on rehabilitation, training, illnesses, and types and frequency of injuries. The seminars provide "hands-on" educational encounters, not only for coaches and trainers, but they also allow physicians to maintain contact with the needs of student athletes.

One addition to the symposia that the committee strongly encouraged all sponsors to implement was discussion of basic first aid. The committee highly recommended that sponsors contact the Red Cross and integrate portions of the basic first aid manual into the symposia syllabus.

The committee discussed the issue of the health examination form, and noted that due to a change in regulation, a specific physical education form will no longer be mandated. In consultation with Terry Vance of the Kentucky Department of Education, and a valued ex-officio member of the committee, the committee recommended that the current form, KHSAA Form 4, should be retained as the standardized physical education form for use by Kentucky physicians.

One of the main items of discussion revolved around the proposal of the Kentucky High School Athletic Association to bring back high school spring football practice for the 1997-98 school year. The proposal would allow each football school to conduct 10 practice periods of not more than two hours in length, and not more than one practice per day over 10 days during the three calendar weeks following the school's elimination from post-season play in basketball. It also allows full contact with football pads and rules out any interschool competition during the three-week period.

As a result of this proposal, the committee discussed at length a report of the American Orthopaedic Society for Sports Medicine (AOSSM). An AOSSM committee, composed of coaches, athletic directors, trainers, team physicians, and sports scientists, studied the effects of spring football practice on student athletes at the Division I and II collegiate levels over a six-year period. The study showed that the spring football practice injury rate is consistently more than double that of fall practice. Following are the rates in more detail:

- 1) The concussion injury rate in spring practice is more than double that of fall practice;
- 2) The anterior cruciate-ligament (acl) injury rate is more than three times the injury rate in fall practice; and
- 3) Injuries requiring surgery in spring practice occur at a rate more than three times that of fall practice.

After carefully reviewing the study of AOSSM, the committee approved the following recommendation which was endorsed by the KMA Board of Trustees and sent to Dr Wilmer S. Cody, Commissioner, Kentucky Board of Education:

In the interest of the health of students actively involved in the sport of football in Kentucky, KMA recommends that the Kentucky Board of Education revise the current KHSAA proposal to allow 10 days of no contact spring practice over the course of three calendar weeks following the school's elimination from post-season play in basketball.

The committee will keep in close communication with the Kentucky Board of Education, as well as with the Kentucky High School Athletic

Association, regarding the implementation of high school spring football practice. The committee wants to ensure that high school athletes competing in the sport of football are able to play when physically fit, and are not subject to risk of injury due to lack of proper conditioning and preparation.

As Chair, I would like to personally thank the members of the Committee on Physical Education and Medical Aspects of Sports for their dedication and expertise during this past year.

**R. Quin Bailey, MD
Chair**

Report of the Committee on Child and School Health

The Committee on Child and School Health met on two occasions during the 1996-97 Association year. The committee continued exploration of the "Adopt-A-Physician" program. The goal of the program is to eventually lead to a contractual agreement between a local physician and a local school so that the physician can advise the school on child health matters. This issue emanated from a concern that teachers and school employees are being asked to perform procedures, such as administration of medication, normally done by nurses and other health professionals. School personnel believe performing these procedures detracts from their teaching time and is an enormous responsibility for which they are not trained.

During the year, Ms Terry Vance, a representative to the committee from the Department for Education, communicated with the superintendents of the school districts in Kentucky to determine which schools would be willing to participate in this program. In the meantime, the committee sent out a letter with the *Communicator* asking for physician volunteers to work with the schools in their area. The committee is working to match the physicians with the schools and formalize the agreements within the coming year.

The committee also worked to implement Resolution 128 — School Health Examinations — which specified that KMA work with the Kentucky Department for Education to develop a set of forms for school examination and student athletic examinations that will be considered an acceptable alternative in all Kentucky districts and discourage the use of multiple forms. One concern that arose within the Department for Education which impeded revision of the school examination forms was a *Forbes* magazine article from December 1996. The article focused on alleged abuse within a Kentucky school district that had resulted from the guidelines of the school health form. Due to the political climate within the Department for Education surrounding the nature of the school form, revisions of the form were put on hold until the attention on the issue subsided.

Rice C. Leach, MD, Commissioner of Health Services, has agreed to work with the Kentucky Department for Education to put the forms on the letterhead of the Cabinet for Health Services so the forms could be properly revised from a student health standpoint. The committee agreed that the end result of the health examination forms should be that the child is healthy and is able to attend school, while ensuring that the examination form is consistent on a statewide basis.

The committee reviewed the issue of administering the TB skin test. Dr Leach reported that the current method of administering the TB skin test is the PPD method. The method of administering the test has changed over the past several years and the committee also discussed the rare incidence of TB in the population. Dr Leach informed the committee that health services has a legislative proposal to rescind the testing of school-aged children for TB and will introduce the legislation in the 1998 General Assembly. The committee will continue to keep abreast of this issue as it develops in 1998.

I would like to thank the members of this committee for their dedication to improving patient care. I would also like to thank the Board for its support of this committee.

**Thomas H. Pinkstaff, MD
Chair**

Report of the Judicial Council

The KMA Judicial Council conducted one formal meeting during the past year; however, other matters were handled informally by telephone and correspondence. The council considered one complaint against a physician who was accused of providing unnecessary medical services and supplies to patients. Various inquiries from physicians were also received throughout the

year regarding the requirement of providing patients copies of medical records pursuant to Kentucky law. The new Workers Compensation Reform Law, passed in December, changed some of the requirements regarding patient medical records. Other concerns regarding this issue continue to arise and physicians are urged to work with patients, insurance companies, and other entities seeking records in order to comply with Kentucky law.

A few times throughout the year, local trustees were called upon to investigate matters in their districts, although none of the investigations turned up any issues to be handled formally by the council.

The council is honored to serve the Association and urges all KMA members to follow their recognized professional responsibilities and obligations.

**William P. VonderHaar, MD
Chair**

Report of the Interspecialty Council

The Interspecialty Council met for the second time in as many years since its reactivation in 1996. The Board of Trustees directed that the council be reactivated in 1996 and that its mission be to promote and improve communications between KMA and the organized medical specialty groups in Kentucky on medical and socioeconomic issues of mutual interest in an effort to unify and strengthen organized medicine in Kentucky, while maintaining the autonomy of the individual specialty societies.

Twenty-three specialty group representatives were invited to attend the meeting. Discussion at the meeting involved a report of the latest initiatives of the AMA Federation Coordination Team which was formed after the AMA Federation Study Committee issued its final report in 1996. It was reported that 95% of physicians belong to a specialty society, 75% to their state association, 90% to their county society, and 42% to the AMA. The AMA Federation Study Committee approved the reorganization of the AMA House of Delegates so that each delegate had a vote to be represented by the state or their specialty society and each specialty society has one delegate.

The goal of the AMA Federation Coordination Team is to coordinate efforts of the Federation and find areas where economies of scale can be reached such as journal activities, computer technology, and coding and nomenclature resources.

The committee also discussed the Medicaid Managed Care Partnerships that are scheduled to be implemented in Kentucky on a region-by-region basis. The goal of each of the eight partnerships is to provide health care through managed care systems consisting of local providers in both the public and private sectors.

The managed care partnerships will participate in the Medicaid program as comprehensive risk-based entities and will be paid on an actuarially sound, capitated basis. The medical schools at the University of Kentucky and the University of Louisville are playing an active role in the design and administration of the managed care entities, particularly in the Lexington area. The Universities are expected to anchor other partnerships in rural areas by providing staff, technical support, and tertiary care.

Finally, the council discussed the history of the KMA Physician's Plan in initiating a PPO. The KMAPP Board is in full support of starting a PPO, but due to the complexity of the business venture, the Board is still searching for a mechanism to facilitate the plans of a PPO.

It is the intent of the council to continue to meet on an as needed basis in an effort to discuss items of interest among organized medicine.

**Robert R. Goodin, MD
Chair**

END OF CONSENT CALENDAR ITEMS

Report of the Committee on Maternal and Neonatal Health

The Committee on Maternal and Neonatal Health considers issues relating to the quality of medical care in obstetric and pediatric services and acts as an advisory body to KMA on matters relating to maternal and child health. This year the committee reviewed and was involved in several issues.

Following the statutory requirement of posting warning signs on substance abuse during pregnancy in bars and physicians' offices, the



committee agreed on the appropriateness of including tobacco warnings in this same material. The genesis for these signs originates in the Department of Mental Health, Division of Substance Abuse. After contact by one of the KMA committee members, it was learned that revision of the posters might require a statutory change because of their statutory base. Rather than making this a legislative issue, the committee felt it most appropriate to keep this within the environs of public health concerns and will attempt to work with the appropriate state agency for necessary changes.

On a related issue, the committee has explored means to routinely provide summary information to members of KMA on maternal and neonatal health issues. An example of such information relates to low birth weight and smoking. Studies have indicated that the elimination of smoking is the number one risk factor for low birth weight babies. While medical science has had success in treating low birth weight babies there has been virtually no reduction in the percentage of low birth weight neonates. The Division of Maternal and Child Health of the Cabinet for Health Services has developed some information on this particular issue which the committee will work to have publicized in routine KMA publications, and the committee will seek similar articles routinely. This activity fulfills one of the committee's assumed duties of acting as an education resource on maternal and child health issues.

A comparable issue is the need for increased folic acid intake by pregnant women, particularly pregnant teenagers. Increased folic acid consumption has proven to be a strong preventive measure for spina bifida. Unfortunately, many pregnant teenagers do not become aware of this factor until after pregnancy has occurred. It was learned that health departments throughout the state have information on folic acid use and the health department has provided it to all schools in the state. The committee feels this is an important issue all physicians should be aware of, and they should provide information to their female patients. While the committee feels that preconceptual counseling on a number of issues is most appropriate, smoking cessation and folic acid use are obvious targets whose elimination would promote healthy pregnancies and neonates.

The committee has been concerned for some time about the requirement for preauthorization for hospitalization for induction of labor in pregnant Medicaid recipients. An oxymoron rule appears to be in play here. According to federal rules, all admissions under the Medicaid program must be authorized. Elective admissions must be preauthorized, and emergency admissions may be authorized after admission. Admission for induction of labor is elective by definition, although all patients admitted for induction will eventually require hospitalization. It appears to be a fairly common practice for local hospitals to obtain "preauthorization" for induction admissions after the fact. However, this type of preauthorization cannot be obtained on week-ends. The committee intends to work with the Maternal and Child Health Division to develop criteria that would justify admissions under these circumstances and be acceptable to the Medicaid program.

The committee considered with great interest recent Congressional action on increased funding for child care, the so-called "kiddy care" bill, and related information developed by the Council on Medical Services of the American Medical Association which was issued in June. It was noted that a task force in Kentucky has worked for some time to develop a program and benefits package for indigent children who did not qualify for Medicaid. Because of this previous work, Kentucky will likely realize \$50-60 million beginning November 1, if the legislation mentioned is signed by the President. It was noted that the legislation provides for \$24 billion for child care funding over the next five years. A little-known provision of the legislation also may extend this funding for an additional five years in the same amount. The committee will continue to monitor this development and its impact on Kentucky.

The committee also considered information by the Board of Trustees of the AMA on the calculation of infant mortality rates. Typically, the United States infant mortality rate has remained relatively high among Western nations and considerable discussion occurred at the AMA level about the method of calculating this rate. The consensus at the AMA and among committee members was that rather than focusing on the rate calculation method, attention more appropriately should be focused on reducing the overall incidence of infant mortality.

The committee considered ongoing developments within the Department of Education to standardize child school health examination forms and to encourage parenting and family life education skills in school curricula. These

have been ongoing interests of the group.

Finally, the committee considered a report on management of the care of infants with apnea in the home setting. This report was developed by the Kentucky Apnea Monitor Task Force, originally convened by the Kentucky Home Health Association Pediatric Services Committee. Two of the members of the KMA Committee on Maternal and Neonatal Health served on this group, in addition to physician representatives from the University of Kentucky and the University of Louisville.

The report was generated by a concern about the treatment, as well as inappropriate treatment, and use of related services and devices for infants with apnea in the home setting. The report is medically driven and contains criteria for diagnosis and management, use of apnea monitors, discharge planning and home management, and the role of all individuals on the health care team in treating this condition. It is intended to be disseminated for use to individuals directly involved in this type of care, which include primary care physicians, nurses, and home health personnel.

To date, this report and accompanying guidelines have been endorsed by the Kentucky Pediatric Society, Kentucky Perinatal Association, and the Department of Maternal and Child Health of the Cabinet for Health Services. The committee feels that this is a solid, useful document. After review by the committee, in addition to input directly by committee members in the development of this material, the committee recommends that KMA endorse this report and its use.

The committee will continue its work in the areas mentioned, as well as seek other ways to expand information on current issues relating to maternal and child health. As chair of the committee, I would like to thank each of the committee members for their individual expert input and devotion to these issues of care.

J. Gregory Cooper, MD
Chair

RECOMMENDATIONS:

1. The Committee on Maternal and Neonatal Health recommends that the Kentucky Medical Association endorse the Consensus Statement of the Kentucky Apnea Monitor Task Force relating to Home Monitoring in Infants with Apnea and Related Conditions.

Recommendations, Reference Committee E:

Reference Committee E reviewed Report No. 34, Committee on Maternal and Neonatal Health, and its Recommendation calling for endorsement of the Consensus Statement of the Kentucky Apnea Monitor Task Force. They noted errors in the wording of the report relating to smoking as the primary risk factor for low birth weight babies. Reference Committee E recommends that Report 34 and its Recommendation be adopted.

Report of the Committee on Community and Rural Health

The Community and Rural Health Committee convened on two separate occasions over the 1996-97 year to consider issues related to health and safety of the community.

One of the major highlights of the year occurred under the auspices of the Subcommittee on Domestic Violence. The subcommittee completed its work in the fall of 1996 on a physicians' education manual on issues relative to caring for patients who have suffered from domestic violence. The comprehensive document entitled "The Model Health Care Protocol on Abuse, Neglect, and Exploitation: Child, Spouse/Partner, Adult and Elder," was mailed to member physicians in March 1997. The release of the document ended a year-long effort by the subcommittee. The development of the manual resulted from a survey showing 76% of physicians in Kentucky were interested in receiving education on identification, treatment, and reporting of domestic violence for patients. To highlight the results of the survey and release of the Model Health Care Protocol, an article was published in the *KMA Journal*, furthering the education of physicians about this community epidemic.

The subcommittee also worked to develop a three-hour educational course for physicians which complies with the new state requirements for primary care physicians. By law, all Kentucky licensed primary care physicians must complete a one-time, three-hour domestic violence education course by June 30, 1999. The subcommittee has planned an excellent program which

will be held during the KMA Annual Meeting. The course has been approved by the Governor's Office on Domestic Violence, the Kentucky Board of Medical Licensure, and the CME Council for three hours of Category 1 CME credit.

The committee also considered timely issues related to public health in the Commonwealth. Rice C. Leach, MD, Commissioner of Public Health, reported to the committee on the efforts of his office to present the Governor's Conference on the Future of Public Health in Kentucky. A planning committee met for over five months to assess topics and find speakers for the three-day conference held in March. In total, over 600 attendees heard prominent local and national health officials discuss the future of how public health will impact and be impacted by the changing nature of the health care delivery system in the Commonwealth and the United States.

Commissioner Leach also shared with the committee information about a potential computerized index registry for death certificates. After various requests from physicians in Kentucky regarding the possibility of having a computerized system of information, Dr Leach has agreed to assess the details of putting a system in place. In addition to the computerized index registry for death certificates, the committee also discussed revising the current death certificate in Kentucky to accurately record the exact cause of death. The committee's concern with the current death certificate was that it is misleading regarding the immediate cause of death versus the underlying cause of death. It was reported that the next revision of the death certificate is scheduled for 1999, but that the committee will continue discussion at subsequent meetings.

Another important subject addressed by the committee was prescription drug abuse. A current problem is one of "doctor shopping" where patients visit several physicians to receive treatment for the same problem in order to obtain a duplicate prescription. John Morse, Secretary, Cabinet for Health Services, expressed a strong desire to work with KMA on finding a solution to the problem. Secretary Morse has pledged his support to this project as it proceeds. It was pointed out that past programs, such as the American Medical Association PADS program, have focused on this problem but, like others, lacked funding and coordination on the state level. Secretary Morse agreed with the committee that a central link network throughout the state with physicians, hospitals, and pharmacies would help organize the wealth of information on prescriptions. The committee also reviewed deliberations of the Attorney General Task Force on Prescription Drug Abuse in which KMA is well represented.

The committee will continue to pursue these current issues and will consider additional health and safety issues in the coming year. The committee anticipates another busy year and would like to thank the Board of Trustees for being permitted to serve.

**Baretta R. Casey, MD
Chair**

Recommendations, Reference Committee E:

Reference Committee E reviewed the Report of the Committee on Community and Rural Health and would like to commend Doctor Casey and members of the Committee for development of the document, "The Model Health Care Protocol on Abuse, Neglect, and Exploitation: Child, Spouse/Partner, Adult and Elder."

Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan

The Ad Hoc Committee to Develop a Comprehensive School Health Education Plan involves itself with the development of a comprehensive school health education plan of which parenting and family life skills is a facet. The committee is hopeful that recommendations will eventually be considered by the Kentucky General Assembly.

The ad hoc committee met on one occasion during the 1996-97 Association year. The committee was informed of the chair's meeting with the Department of Education (DOE) regarding the core curriculum guidelines for health education handed down to local schools. These guidelines have been significantly expanded and direct local Boards of Education to include certain topics if they choose to teach health education. In addition, the committee was also apprised of a meeting with the Kentucky School Board (KSB) Subcommittee on Health Education which involves itself with the "weight" of health education in relation to KIRSIS testing of students. The

recommendations to the KSB on behalf of this committee were as follows:

1. Include health education as a separate item or at least list with Practical Living.
2. Make a philosophical increase in the weighting system to encourage schools to make note of the importance of CSHE to the KSB and DOE. We suggest increases from the current 3% to 5-7%. This minimal increase would not affect the importance of other academic areas. This could even be taken from the current 16% in the noncognitive index area.
3. Ask DOE to establish a division to facilitate schools in implementing CHSE.
4. Ask for KEA support for CSHE and to express such support to the KSB.
5. Ask for DOE to support CSHE by funding divisional support for facilitating CSHE.

A written response to these recommendations was promised to the KMA committee by the School Board Subcommittee. The KMA committee also presented the same recommendations to the KEA Board which voted unanimously to support the recommendations and forwarded its recommendation to the DOE. The committee will determine its next step after hearing from the School Board and after reviewing the KEA recommendation to the Board.

An "Action Sheet" for physicians was submitted by the committee chair for publication in the *KMA Journal*. This was a one-page article to assist physicians in ways to aid in implementing school health education in their local schools. The article was submitted for publication in the *KMA Journal* and appeared in the December 1996 issue.

The committee recognizes the need to develop a plan of action and promote our goals on two levels.

- (1) State Level: The committee will continue to work with various individuals and with departments and cabinets as appropriate. Specifically, we plan to work with the Department of Education, Board of Education, and legislators known to be interested in school health education. In addition, we are working with a statewide organization and committee organized by the American Cancer Society, Kentucky Chapter.
- (2) Local Level: As noted previously in this report, we published the committee's "Action Sheet" in the *KMA Journal* encouraging physicians to become active in school health education in their local communities, and communicate with civic and medical organizations such as the local county medical societies, hospital staffs, and organizations such as the American Cancer Society. In addition, we are aware of the tremendous work being done by the KMA Alliance and we encourage them to continue their efforts and to keep this committee aware of their statewide and local efforts.

Following a lengthy discussion on ways to implement comprehensive school health education, the following motion was adopted by the committee:

The KMA Ad Hoc Committee to Develop a Comprehensive School Health Education Plan, in promotion of preventative care, recommends that the KMA support the use of a portion of state funds (ie, Medicaid, education, agriculture, transportation, etc) for use in comprehensive school health education programs.

The recommendation was subsequently referred to the KMA Board of Trustees for consideration and action. At its November 7 meeting, the KMA Executive Committee amended the committee's recommendation to the Board to read:

The KMA Ad Hoc Committee to Develop a Comprehensive School Health Education Plan, in promotion of preventative care, recommends that the KMA support the use of a portion of state funds that are currently available for use in comprehensive school health education programs.

This recommendation was adopted by the full KMA Board of Trustees at its December 1996 meeting and a letter was mailed to the Secretary of Health Services outlining KMA's recommendation and request for support of comprehensive school health education programs.

On behalf of the ad hoc committee members, we appreciate the widespread support for the committee's charge. Accomplishing the goals as outlined in the charge will require personal involvement by physicians and spouses in the legislative and regulatory process. We will continue our efforts to complete the task at hand and the committee urges physicians and others to make known any recommendation or ideas they have to either committee members, their KMA representatives, or staff. Thanks are accorded to the KMA Board of Trustees for their continued support and encouragement.

**Thomas L. Young, MD
Chair**



Recommendations, Reference Committee E:

Reference Committee E reviewed the Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan and noted some typographical errors in the report. Reference Committee E recommends that the Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan be filed.

RESOLUTION 97-101

Reduction of Tobacco Use While Assuring Community Economic Stability Estill County Medical Society

WHEREAS, the public health community recognizes that the production of tobacco plays a significant role in the economic maintenance of many American families living in tobacco states; and

WHEREAS, the tobacco-producing community recognizes that tobacco use is this nation's leading cause of preventable disease and death; and

WHEREAS, the public health community is sensitive to the uncertainties that tobacco growers and their families have about their future and being able to make a living and provide for their families; and

WHEREAS, the public health community recognizes that eliminating the tobacco program will not necessarily reduce the use and consumption of tobacco; and

WHEREAS, the public health community and tobacco-producing communities agree that there are opportunities for working cooperatively to meet both the public health objectives, as well as ensuring economic stability in tobacco-growing states; and

WHEREAS, the public health community will actively work toward providing tobacco-producing communities viable economic options for diversification, as well as ensuring assistance for economic development; and

WHEREAS, the tobacco-producing communities will support meaningful and fair standards governing the manufacturing, sale, distribution, labeling, and marketing of tobacco products; now, therefore, be it

RESOLVED, that KMA supports coordinated solutions to the health problems caused by tobacco use in the Commonwealth of Kentucky; and be it further

RESOLVED, that KMA supports the provision of new opportunities to farmers in tobacco-growing communities to assure economic stability independent of tobacco production.

RESOLUTION 97-102

Community Authority for Reduction of Tobacco Use by Children Estill County Medical Society

WHEREAS, cigarette smoking kills more Americans each year than alcohol, car accidents, homicide, suicide, illegal drugs, fires, and AIDS combined; and

WHEREAS, over 8,000 people from Kentucky die of tobacco-caused diseases each year; and

WHEREAS, Kentucky has one of the highest rates of tobacco use among children in the United States, according to the Centers for Disease Control and Prevention; and

WHEREAS, rates of smoking among children in Kentucky are increasing; and

WHEREAS, every 30 seconds a child in Kentucky smokes for the first time and one-third of these new smokers will eventually die of tobacco-related diseases; and

WHEREAS, of 10 new smokers, 9 will be teenagers; and

WHEREAS, the tobacco companies have as one of their chief legislative strategies to remove local authority to control tobacco use; and

WHEREAS, citizens in local communities believe they should have the power to protect children from tobacco products; and

WHEREAS, KMA is concerned about the health hazards of smoking and the use of tobacco by children; and

WHEREAS, the current laws of the state of Kentucky, including SB 137, cripple local governments by not allowing them to pass stronger laws restricting use, sale, distribution, or display of tobacco products; and

WHEREAS, KMA believes that there should be a uniform, statewide minimum youth access law and local communities should be allowed to enact and enforce stricter tobacco-related ordinances if they choose to do so; now, therefore, be it

RESOLVED, that KMA urges the Kentucky General Assembly to allow local communities to enact and enforce stricter tobacco-related ordinances if they choose by revising language contained in SB 137 (1996); and be it further

RESOLVED, that KMA encourages other interested health and community organizations to adopt similar positions; and be it further

RESOLVED, that copies of this resolution be furnished to the Governor and members of the Kentucky General Assembly.

RESOLUTION 97-111

Smoking in Children Fayette County Medical Society

WHEREAS, cigarette smoking kills more Americans each year than alcohol, car accidents, homicide, suicide, illegal drugs, fires, and AIDS combined; and

WHEREAS, over 8,000 people from Kentucky die of tobacco-caused diseases each year; and

WHEREAS, Kentucky has one of the highest rates of tobacco use among children in the United States, according to the Centers for Disease Control and Prevention; and

WHEREAS, rates of smoking among children in Kentucky are increasing; and

WHEREAS, every 30 seconds a child in Kentucky smokes for the first time and one-third of these new smokers will eventually die of tobacco-related diseases; and

WHEREAS, of 10 new smokers, 9 will be teenagers; and

WHEREAS, the tobacco companies have as one of their chief legislative strategies to remove local authority to control tobacco use; and

WHEREAS, citizens in local communities believe they should have the power to protect children from tobacco products; and

WHEREAS, KMA is concerned about the health hazards of smoking and the use of tobacco by children; and

WHEREAS, the current laws of the state of Kentucky, including SB 137, cripple local governments by not allowing them to pass stronger laws restricting use, sale, distribution, or display of tobacco products; and

WHEREAS, KMA believes that there should be a uniform, statewide minimum youth access law and local communities should be allowed to enact and enforce stricter tobacco-related ordinances if they choose to do so; now, therefore, be it

RESOLVED, that the Kentucky Medical Association seek legislation to amend the preemptive language in SB 137 to return rights to local communities to enact and enforce stricter tobacco-related ordinances if they choose to do so; and be it further

RESOLVED, that the Kentucky Medical Association strongly encourages other health organizations to adopt similar resolutions; and be it further

RESOLVED, that copies of this resolution be distributed to the Governor and the Lieutenant Governor of Kentucky, to all members of the 1998 Kentucky General Assembly, all Kentucky mayors and county judge executives, and to the Kentucky Department for Public Health.

RESOLUTION 97-135

Sale of Tobacco Board of Trustees

WHEREAS, the Kentucky Medical Association was extremely successful during the 1996 Kentucky General Assembly by working with the Kentucky Farm Bureau, Kentucky Retail Federation, representatives of the Tobacco Industry, and Governor Patton in enacting Senate Bill 137; and

WHEREAS, in accordance with KMA House of Delegate directives, Senate Bill 137 sharply restricted the purchase and sale of tobacco to children, increased fines, and funded enforcement provisions of the new law which has been recognized to be very effective; and

WHEREAS, one provision which the Kentucky Medical Association sought to include in Senate Bill 137 permitting local communities to adopt more stringent laws which local authorities deem appropriate was not accepted by the parties and strongly resisted by the Kentucky General Assembly; now, therefore, be it

RESOLVED, that KMA reaffirms support for local municipalities and counties to adopt more stringent laws and regulations governing the sale and use of tobacco in local facilities; and be it further

RESOLVED, that smoking restrictions in state facilities used by the public in local communities be governed by the same local laws or regulations affecting other local businesses and privately owned facilities; and be it further

RESOLVED, that KMA continue to support both additional state taxation on tobacco products to discourage use of tobacco products by minors and public funding of the development of agricultural alternatives to growing and processing of tobacco and tobacco products.

Recommendations, Reference Committee E:

Reference Committee E reviewed Resolutions 101, 102, 111, and 135, all dealing with the issue of tobacco use, and recommends the adoption of Resolution 135, Sale of Tobacco, introduced by the Board of Trustees, in lieu of Resolutions 101, 102, and 111.

RESOLUTION 97-125

Commercial Poultry and Swine Industry Estill County Medical Society

WHEREAS, all Kentuckians share a common interest in assuring the environmental and economic well-being of the Commonwealth, especially at this time of crisis for the thousands of small Kentucky tobacco farmers; and

WHEREAS, during the past year, commercial swine and poultry operations have targeted Kentucky for production and processing facilities which could more than triple current production levels; and

WHEREAS, the geology of the West Kentucky area involved is heavily karstified with sinkholes, porous limestone, and caves, raising the possibility of fecal and chemical contamination of public and private drinking water sources; and

WHEREAS, a two-year moratorium on commercial hog farms imposed by Governor Hunt in North Carolina in 1997, the nation's 2nd leading hog producing state in the nation, could result in even more operations locating in Kentucky; and

WHEREAS, there are significant environmental, economic, and quality of life concerns associated with the development of intensive commercial swine and poultry raising and processing facilities that have not been fully studied or addressed in Kentucky; and

WHEREAS, a low-fat, high-fiber diet (emphasizing grains, vegetables, fruits, legumes, and low-fat animal foods) is the consensus of public health nutritional guidelines of organizations including the National Heart, Lung, and Blood Institute (National Cholesterol Education Program), the National Cancer Institute (5-A-Day Program), the Centers for Disease Control and Prevention (5-A-Day Program), the US Department of Agriculture (Food Guide Pyramid), and the American Heart Association (Dietary Guidelines for Adult Americans); and

WHEREAS, Governor Patton has imposed a "suspension" for all swine operations until the development of Emergency Regulations by the Natural Resources and Environmental Protection Cabinet (said 90-day suspension to expire 10/23/97); now, therefore, be it

RESOLVED, that Governor Patton extend his current moratorium on new and expanded commercial poultry and hog operations to include a Blue Ribbon Panel composed of national and state experts; local government officials; state government, environmental, agriculture, and economic development officials; legislators; academia; farmers; special interest groups, and environmental interests conduct the study to include, but not be limited, to the following:

- A. An economic analysis to determine if large or commercial poultry and hog operations are a suitable industry for Kentucky; to include potential impacts and disruption to small independent farmers; appropriateness of state financial incentives; alternatives for sustainable agricultural economic development, such as grower-owned cooperative processing ventures; and other economic costs and benefits that may occur in Kentucky associated with large hog and poultry operations.
- B. A full assessment of environmental impacts as well as regulatory and other needs including, but not limited, to the following:
 1. The development of an environmental permitting program, or the expansion of the state's existing permitting programs, with opportunities for full public participation in regard to commercial hog and poultry facilities and associated production operations to address the following:
 - a. Water withdrawal needs for processing operations and assurances

that surface and ground water withdrawals will not adversely affect the public interest or jeopardize the right of other users;

- b. Wastewater discharges from processing facilities and regulatory assurances that these pollutants will not degrade ground and surface water resources.
- c. Solid waste disposal practices for wastes associated with production and processing, as well as proper disposal of dead animals lost at production operations and sick or contaminated animals rejected during processing.
- d. Odors and other air emissions caused by operations and measures needed to protect residents in the vicinity of operations.
- e. The proper design and location of wastewater lagoons, taking into consideration the vulnerability and sensitivity of groundwater resources and other site characteristics.
- f. Landfarming and disposal of poultry and hog manure and other wastes and measures needed to adequately protect ground and surface waters from contamination.
- g. Guidelines for site suitability.
2. A policy to require a comprehensive assessment of environmental records of companies, as well as parent and related entities, and the key personnel who will manage the operations to ensure these companies are committed to sound environmental principles.
3. Development of an educational program for contract farmers and those considering growers' contracts to include training in managing waste and other practices to address and prevent environmental problems associated with poultry and hog operations.
4. Development of a mechanism to allow for early public and community input and participation in the siting of commercial or large hog and poultry operations and related facilities; and be it further

RESOLVED, that this moratorium remain in effect no longer than May 31, 1998, in order to conduct this study and consider any legislative and regulatory measures necessary to address environmental and economic concerns; and be it further

RESOLVED, that this resolution be forwarded to Governor Paul Patton and Lieutenant Governor Stephen Henry for their consideration; and be it further

RESOLVED, that the KMA endorses the emerging national nutritional consensus urging Americans to shift their eating patterns toward a high-fiber, low-fat diet emphasizing grains, fruits, vegetables, and low-fat animal products; and be it further

RESOLVED, that the KMA supports intensive efforts by Kentucky's agricultural leadership to protect Kentucky's tradition of small family farms and encourages the use of the above national nutritional consensus as a framework for priority decision-making about agricultural diversification.

Recommendations, Reference Committee E:

Reference Committee E next considered Resolution 125, Commercial Poultry and Swine Industry, introduced by the Estill County Medical Society, and recommends the deletion of all the language in the first Resolved following the words, "conduct the study" and the deletion of the second, fourth and fifth Resolveds. The remaining Resolveds would then read:

RESOLVED, that KMA support Governor Patton's extend his extensions of the current moratorium on new and expanded commercial poultry and hog operations and to include support a the work of the Blue Ribbon Panel appointed composed of national and state experts; local government officials; state government, environmental, agriculture, and economic development officials; legislators; academia; farmers; special interest groups, and environmental interests to conduct a the study of the subject; and be it further

RESOLVED, that this resolution be forwarded to Governor Paul Patton and Lieutenant Governor Stephen Henry for their consideration.

Mr Speaker, Reference Committee E recommends adoption of Resolution 125 as amended.

John A. Patterson, MD, Irvine, addressed the House and indicated that the reference committee report did not accurately reflect the committee's intent on this resolution. Because of some confusion in the wording and the current status of the Governor's position on this matter, Doctor Patterson recommend referral to the Board of Trustees. Motion carried. Resolution 97-125 was referred to the Board.



RESOLUTION 97-130

Phen-Fen Prescriptions

Fayette County Medical Society

WHEREAS, more and more states are beginning to ban the use of Phen-Fen; and

WHEREAS, more medical hazards are being reported with the use of this combination of medications; and

WHEREAS, patients are financially taken advantage of through multiple diet centers; now, therefore, be it

RESOLVED, that the Kentucky Medical Association wants to have Phen-Fen available for appropriate patients through prescription by licensed physicians; and be it further

RESOLVED, that the Kentucky Medical Association ask the Attorney General's Task Force on Prescription Drug Abuse to include Phen-Fen in their deliberations to assure appropriate prescribing of these drugs.

Recommendations, Reference Committee E:

Reference Committee E next considered Resolution 130, Phen-Fen Prescriptions, submitted by the Fayette County Medical Society. Discussion on the floor of the House indicated that the Food and Drug Administration had recently announced action to remove these drugs from the market, so the resolution becomes moot.

The substitute for Resolution 97-130 was rejected. Subsequently, the original Resolution 97-130 was also rejected.

RESOLUTION 97-136

Tobacco Settlement

Board of Trustees

WHEREAS, State Attorneys General, trial lawyers, tobacco companies, and medical and public health industry representatives are attempting to negotiate a nationwide settlement of various lawsuits filed by states and individuals against the tobacco industry; and

WHEREAS, the American Medical Association is a member of the negotiating committee and can best represent KMA's position as it relates to negotiations and development of legislation relating to advertising, sale and use of tobacco; and

WHEREAS, state attorneys negotiated settlement by the various parties will ultimately require Congressional passage of legislation that will engender intense discussion, negotiation, and compromise between the various parties; now, therefore, be it

RESOLVED, that the Kentucky Medical Association commends, supports and encourages AMA's representation of the federation of medicine in the negotiations; and be it further

RESOLVED, that the KMA supports AMA's historical support for FDA regulation of tobacco and complete and total ban on the sale and marketing of tobacco products to children; and be it further

RESOLVED, that any settlement should include provisions that protect tobacco farmers and workers by funding programs which finance transition from growing tobacco to food or other farming products or services; and be it further

RESOLVED, that the Kentucky Medical Association monitor ongoing negotiations and subsequent legislation and communicate the Kentucky Medical Association's position to the American Medical Association and Kentucky's Congressional Delegation.

Recommendations, Reference Committee E:

Reference Committee E next considered Resolution 136, Tobacco Settlement, introduced by the Board of Trustees, and recommends deletion of the first Resolved, substituting the following:

RESOLVED, that the KMA express to the AMA its support for the Koop Kessler proposal and its concern about provisions of the current settlement which allow immunity and preemption for the tobacco industry.

Reference Committee E recommends that Resolution 136 be adopted as amended.

After much discussion on the floor of the House a motion was made to refer the resolution to the Board of Trustees. Resolution 97-136 was referred to the Board of Trustees.

Mr Speaker, Reference Committee E recommends the adoption of the

report of Reference Committee E as a whole, as amended.

Mr Speaker, I would like to thank the other members of this committee — John S. Cave, MD, Henderson; Cecil D. Martin, MD, Carrollton; Barbara A. Phillips, MD, Lexington; J. Michael Pulliam, MD, Franklin; and Edward L. Scofield, MD, Louisville — for their time and thoughtful consideration of the issues referred to the reference committee. The Chair would also like to thank Ms Jean Wayne for her assistance in the preparation of this report.

Respectfully submitted,

REFERENCE COMMITTEE E

John A. Patterson, MD, Irvine, Chair

John S. Cave, MD, Henderson

Cecil D. Martin, MD, Carrollton

Barbara A. Phillips, MD, Lexington

J. Michael Pulliam, MD, Franklin

Edward L. Scofield, MD, Louisville

Proposed Constitutional Amendment

A proposed constitutional amendment was presented to the House of Delegates at its First Meeting during this session. Baretta Casey, MD, Pikeville, recommended a revision to that proposal in order to provide student representation from each medical school in Kentucky. The following proposal was approved to be distributed to each county medical society at least two months prior to the 1998 KMA House of Delegates, and voted on by the 1998 House.

PROPOSED CONSTITUTIONAL AMENDMENT

Article VI, Section 2:

Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex-officio members of the House of Delegates and entitled to vote. *[The following members shall be designated as ex-officio members of the House of Delegates of the Kentucky Medical Association and entitled to vote: Officers of the Association, Delegates and Alternate Delegates of the American Medical Association, and five immediate Past Presidents; the Dean of the University of Kentucky College of Medicine; the Dean of the University of Louisville School of Medicine; a representative of the Resident Physician's Section of the Kentucky Medical Association; a student representative of each medical school of Kentucky; and a representative of the Organized Medical Staff Section of the Kentucky Medical Association.]* All other past Presidents and Vice Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Tellers Harold L. Bushey, MD, Barbourville; Charles Bea, MD, Mayfield; and F. Douglas Scutchfield, MD, Lexington, were thanked for their efforts.

The Speaker then announced winners of the KEMPAC raffle.

Election of 1998 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 1998 KMA Nominating Committee:

Susan M. Berberich, MD, Louisville, Chair

Lucian Y. Moreman, MD, Elizabethtown

Mary Jo Ratliff, MD, Pikeville

Dennis B. Kelly, MD, Lexington

John S. Cave, MD, Henderson

Harry W. Carlross, MD, Chair, Board of Trustees, made a motion on behalf of the Board that Nelson B. Rue, MD, of Bowling Green, be elected to a four-year term on the Judicial Council. Dr Rue was appointed by acclamation.

Election of Officers

P. Bruce Barton, MD, Chair of the Nominating Committee, presented the slate of nominees for offices, as follows:

President-Elect Don R. Stephens, MD, Cynthiana

Dr Stephens was elected by acclamation, and was escorted to the podium by Past Presidents Donald C. Barton, MD, and Robert R. Goodin, MD. The following nominees were also elected by acclamation:

Vice President	Harry W. Carloss, MD, Paducah
Delegate to the AMA (1/1/98-12/31/99)	Donald C. Barton, MD, Corbin
Delegate to the AMA (1/1/98-12/31/99)	Ardis D. Hoven, MD, Lexington
Alternate Delegate to the AMA (1/1/98-12/31/99)	J. Gregory Cooper, MD, Cynthiana
Alternate Delegate to the AMA (1/1/98-12/31/99)	Baretta R. Casey, MD, Pikeville

Dr Bornstein then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

2nd District Trustee	Donald R. Neel, MD, Owensboro
2nd District Alternate	David A. Watkins, MD, Henderson
7th District Trustee	John M. Patterson, MD, Frankfort
7th District Alternate	Kenneth L. Oder, MD, Taylorsville
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13th District Trustee
13th District Alternate

John R. White, MD, Lexington
David C. Liebschutz, MD, Danville
Kenneth R. Hauswald, MD, Ashland
Maurice J. Oakley, MD, Ashland

Richard F. Hench, MD, Lexington, Chair of the Kentucky Medical Insurance Company Board of Directors, presented an update on Kentucky Medical's status and activities.

Preston P. Nunnelley, MD, Chair of the KMA Public Education Committee, updated the House members on the four-year-old committee's activities. He referred to *Mediscope*, the committee's patient-friendly publication, and encouraged more physicians to order additional copies for their offices. He also reported on cooperative efforts with the Alliance, such as the brochures made available to schools. These materials have come from various sources, and he noted that the committee now plans to develop its own ideas on such things as a coloring book on anatomy, and a checklist for healthy living. Dr Nunnelley reported that the committee was now on the Internet and there were plans to put *Mediscope* on the Internet as well. He then showed a membership recruitment video which had been updated this year in conjunction with the KMA membership office.

Dr Mitchell was called to the podium and made brief remarks as Immediate Past President.

Newly installed KMA President C. Kenneth Peters, MD, next addressed the House. Dr Peters stressed the need for widespread participation by all physicians.

Baretta Casey, MD, reminded the House that two seminars were being offered on Thursday which met the mandatory education requirements on domestic violence and HIV.

Speaker McClellan adjourned the 1997 Session of the KMA House of Delegates at 10:30 PM.

1997-98 KMA Committees

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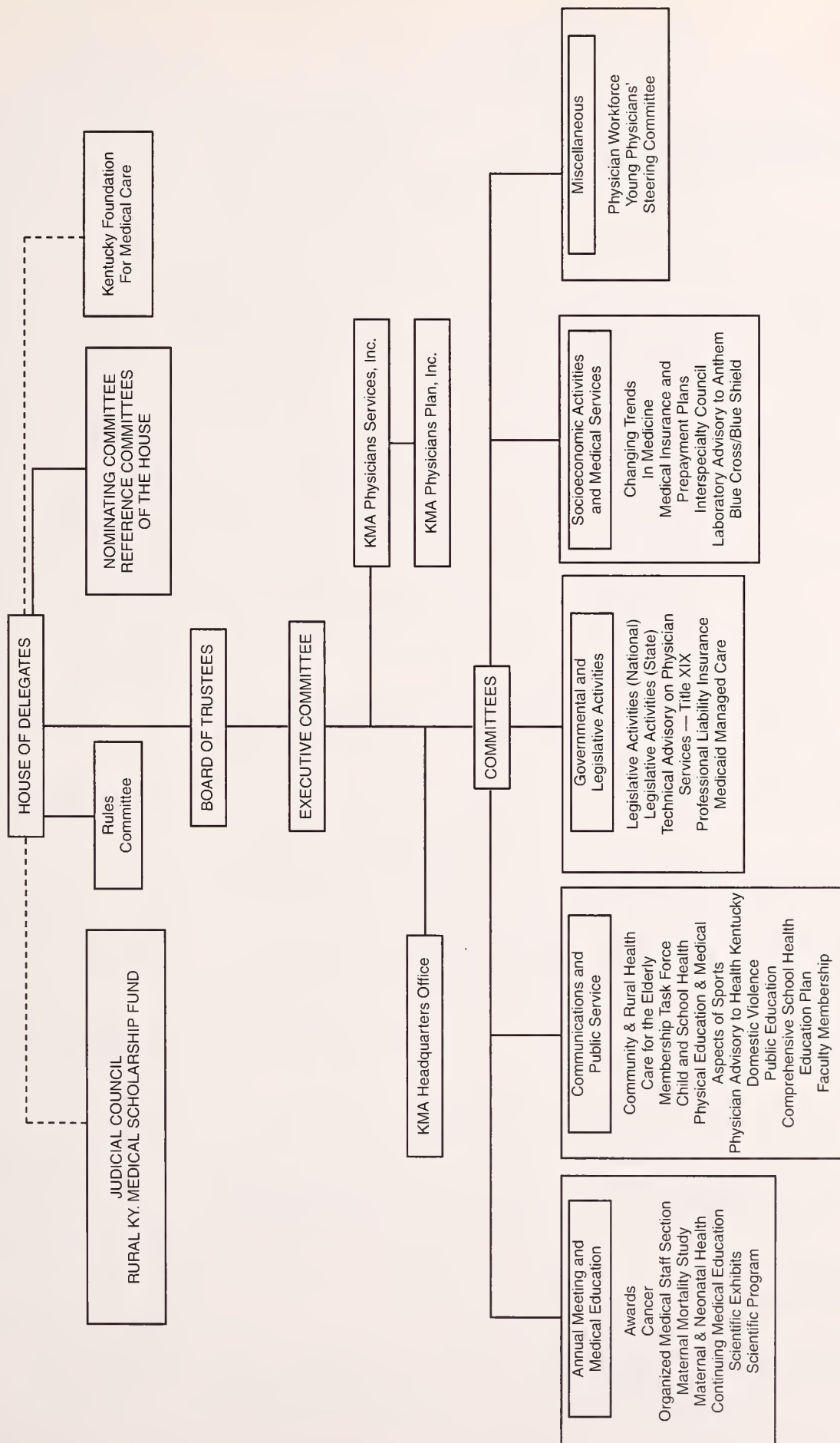
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KMA Organization Chart—Revised September 1997



Cumulative Index *The Journal of the Kentucky Medical Association* Volume 95 — 1997

Month	Pages
January	1 to 48
February	49 to 88
March	89 to 124
April	125 to 172
May	173 to 216
June	217 to 256
July	257 to 304
August	305 to 368
September	369 to 408
October	409 to 448
November	449 to 496
December	497 to 592

Edited by A. Evan Overstreet, MD
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SCIENTIFIC ARTICLES

A

- Aneurysm Associated With a Horseshoe Kidney, Retroperitoneal Repair of an Abdominal Aortic, 143
Aneurysms in Patients With Non-Related Blunt Traumatic Injuries, Spontaneous Rupture of Abdominal Aortic, 64
Arthritis and the Pulmonary Nodule, Rheumatoid, 19

C

- Communicable Diseases Using Hospital Discharge Data, Results of a Search for Missed Cases of Reportable, 237

E

- Epstein-Barr Virus Illness, Manifestations of Relapsing, 240

G

- Genitalia (Grand Rounds), Diagnostic Evaluation and Management of the Child With Ambiguous, 135
Goiter, Surgical Management of Intrathoracic, 421

H

- Hematuria in Adolescents, The Evaluation and Treatment of Prolonged, 315

I

- Incontinence in Children (Grand Rounds), Advances in the Management of Urinary, 226

L

- Laser in the Ear and Brainstem (Grand Rounds), Surgical Applications of the, 13

- Leukemia After Chronic Myelogenous Leukemia, Acute Bilineage, 393
Leukemia: Diagnosis and Treatment, Polymphocytic, 465
Lithium Poisoning in a Child, Acute Accidental, 59
Liver Lesions (Grand Rounds), The Role of Surgery in the Treatment of Benign, 273
Lumbar Radicular Pain, A Fatal Illness Presenting as S1 Radiculopathy — Vascular Causes of, 268
Lymphadenitis in the Adult, Tuberculous, 197

N

- Nasal Trauma for Primary Care Physicians, Diagnosis and Management of, 386

R

- Reflux: A Modern Day "Great Masquerader" (Grand Rounds), Laryngopharyngeal, 378

S

- Surgical Implications of Primary Hypercoagulable States, The, 67

T

- Thrombosis, A Rare Uterine Tumor Presenting as Deep Venous, 102
Tuberculosis in Kentucky: Current Recommendations for Empiric Therapy, 99

W

- Wilms' Tumor in an Adult: A Case Report and Review of the Literature, 191

- Adoumia, R, MD, 143
Ahkee, Sunket, MD, 99
Akin, Cem, MD, PhD, 465
Auslander, Michael B, DVM, MSPH, 237

B

- Baker, Mary, RN, MSN/MHA, 421
Barker, Robert L, PhD, 393
Bergamini, Thomas M, MD, 67
Buchino, John J, MD, 191
Butler, David, MD, 191
Byrd, Robert W, MD, 19
Byrd, Ryland P, Jr, MD, 19, 197

C

- Campbell, Jeffrey P, MD, 386
Carrillo, Eddy H, MD, 64

E

- Earle, Gary F, MD, 421

F

- Finger, Reginald, MD, MPH, 237

G

- Gaar, Earl, MD, 268
Ginzberg, Enrique, MD, 64

H

- Hamman, J, MD, 143
Hansen, Patricia, MD, 465
Hawkins, Brian L, MD, 378
Hester, T Oma, MD, 386
Hourigan Jon, 268

J

- Janckila, Anthony J, PhD, 393, 465

SCIENTIFIC AUTHORS

A

- Aaron, Jannice O, MD, 268

Jose, Baby, MD, 191
Jouja, Kahled, MD, 99

L

Lindberg, Robert D, MD, 191

M

Martin, Larry, MD, 64
Mehta, Jay B, MD, 197
Mizrahi, Solly S, MD, 273

N

Nachbauer, Craig, MD, 421
Namas, Nicholas, MD, 64
Nissen, Alan J, MD, 13

O

O'Connor, Dennis M, MD, 102

P

Paris, Kristie J, MD, 191
Postel, Gregory, MD, 268

R

Ramirez, Julio A, MD, 99
Richardson, J David, MD, 67
Rogers, Anthony G, MD, 421
Roy, Thomas M, MD, 19, 197

S

Saha, Siby P, MD, 421
Savage, John Van, MD, 226, 315
Sewell, Catherine L, MD, 197
Shields, R Eric, MD, 268
Slaughenhaupt, Bruce L, MD, 135, 226, 315
Simon, Michael W, MD, PhD, FAAP, 59, 240
Spanos, William J, Jr, MD, 191

T

Theurer, Heather Hoffmann, MD, 102

U

Uyamadu, Nathan, MD, 99

W

Wellhausen, Samuel R, PhD, 393
Williams, Sheron R, MD, 393
Wojda, Barbara, MD, 99

SPECIAL ARTICLES

Alcoholism Among Adolescents in an Urban Private
Family Practice, The Practicality of Using the
SMAST and AUDIT to Screen for, 105
Domestic Violence: The Physician's Role, Breaking the
Cycle of, 150
Kentucky Medical Curriculum, A Response to the Call
for Educational Reform: A GPEP Report Card, The,
25
Henry, MD — Physician, Politician, Persona, Lt
Governor Stephen L, 280
Kentucky Emergency Medical Services Information
System: Current Progress and Future Goals, The,
509
Interprofessional Code — Kentucky Medical Association
and Kentucky Bar Association, 469
Peters, MD, KMA President 1997-98, Profile — C.
Kenneth, 432
Results of the Kentucky High School Football Knee
Injury Survey, 458
Tornado Disasters and Stress Responses, 145
25 Years — A Look Back, 425
Violence in Medical Facilities: A Review of 40 Incidents,
182

SPECIAL ARTICLES AUTHORS

Blondell, Richard D, MD 105

Caborn, David N M, 458
Calhoun, Robert, MPH, 509
Casey, Baretta R, MD, 150
Feldmann, Theodore B, MD, 182
Foster, Alexandra I, 105
Godleski, Linda S, MD, 145
Hellard, Scott, MD, 182
Holt, Joseph, MD, 182
Jarecky, Roy K, EdD, 25
Looney, Stephen W, PhD, 105
Nyland, John A, EdD, PT, ATC, 458
Ray, J Michael, MD, 458
Rubeck, Robert F, PhD, 25
Schmidt, C. William, 425
Spurlock, Carl W, PhD, 509
Sternes, Roy, MS, PA, ATC, 458
Stocker, Brian D, 458
Svenson, James E, MD, 509
Tharp, Sue, 280, 432
Wilson, David, MD, 25
Wilson, Emery A, MD, 25

IN RETROSPECT

Medicine . . . 100, 75, & 50 Years Ago, 200

MEDICO-LEGAL

Audits, Investigations, and Serious Trouble, 480
Kennedy/Kassebaum: What Physicians Should Know
About This New Law, 287

MEDICO-LEGAL AUTHORS

Hasselbacher, Martha J, 480
Murphy, Marc S, 480
Padgett, Patrick T, 287

SPECIAL COMMUNICATION

Computer Requirements for Medical School Students —
Implications for Admissions, 429

SPECIAL COMMUNICATION AUTHORS

Blue, Amy V, PhD, 429
Bonaminio, Giulia, PhD, 429
Elam, Carol L, EdD, 429
Nora, Lois Margaret, MD, JD, 429
Rubeck, Robert F, PhD, 429

SPECIAL FEATURES

Delegate Roll Call, 532
Digest of Proceedings, 1997 House of Delegates, 535
Index to Proceedings & Reports, 536
Index to Journal Volume 95 — 1997, 586
KMA Committees, 582
KMA Organization Chart, 585
KMA Reference Committees, 538

ASSOCIATION NEWS

A

Annual Meeting, Louisville Hosts 1997 KMA, 264
Annual Meeting Preliminary Program, 325
Applegate Named KMA Executive Vice President,
William T, 39
Awards Nominations Form, KMA, 207

B

Board of Trustees Spring Board Meeting, 250
Board of Trustees — December Meeting, KMA, 80
Board of Trustees Meeting, August, 445
Board of Trustees New Officer Profiles, KMA 248

C

CATO Society Meeting, Kentucky State-Wide, 488

D

Deceased Physicians, In Memoriam, 507

E

Exhibit Guide, KMA Annual Meeting, 356
Exhibits, Application for Scientific, 215, 244

M

Maxey Elevated to KMA Executive Staff, Diane M, 483
Membership at UK Takes Dramatic Leap, KMA 208
Monitoring Medicine, 7, 55, 95, 131, 179, 223, 263, 311,
375, 419, 455, 505

N

News, 41, 82, 117, 163, 210, 251, 296, 402, 442, 491

P

Padgett and Brett A Leichhardt Join KMA Staff, Patrick T,
40
Physician's Recognition Awards, 486
Practice Management Seminars, KMA, 165

R

Reference Committee A — AMA House of Delegates,
442
Reference Committee B — AMA House of Delegates,
Report of, 295
Reference Committee C (Medical Education), AMA
Annual Meeting, June 1997, Actions of, 323
Reference Committee E — AMA Annual Meeting,
Actions of, 484

S

Stephens, MD, Nominated KMA President-Elect, Donald
R, 167

T

Trends in Medicine, Report on Fraud and Abuse Laws,
Committee to Investigate Changing, 489

EDITORIALS

Consumerism, 515
Criticism and Medicine, 35
Devotional, A Daily, 245
Doctor Bone, 399
French Paradox, Confounded, The, 437
Human Guinea Pigs — Protecting Human Subjects, 109
Keep in Touch, 75
"Managed Carefully," 319
Plague, The Coming, 475
Plateau, Before the, 203
Shoe on the Other Foot, The, 157
"Twernt Nothing Serious, 291

EDITORIALS AUTHORS

Alumbaugh, Kimberly A, MD, 203
Burns, Carolyn D, MD, 245
Miller, Milton F, MD, 291
Miller, Richard L, DDS, PhD, 109
Overstreet, A. Evan, MD, 437, 515
Smith, Stephen Z, MD, 35, 319
Stulc, Jaroslav P, MD, 157, 475
Varga, Daniel W, MD, 75, 399

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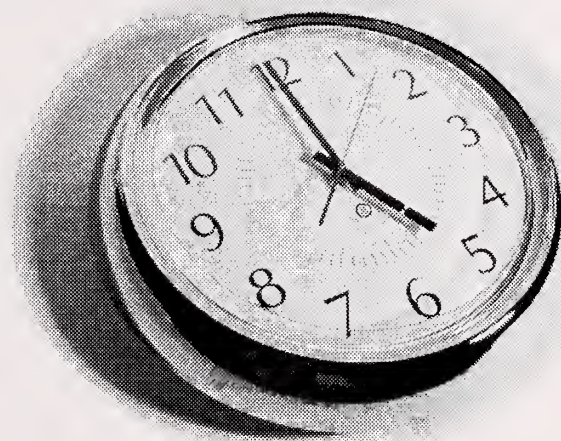
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